Financial Liaison
140 West Main Street • Cuba, NY 14760
(716) 375-6080 • Fax (716) 375-6936

APPLICATION FOR FINANCIAL ASSISTANCE PROGRAM

Date of Request: ________________

Request for Determination of Eligibility for Financial Assistance Program

I hereby request that Cuba Memorial Hospital make a written determination of my eligibility for the Financial Assistance Program. I understand that the information requested below concerning my annual income and family size is subject to verification by the Cuba Memorial Hospital. I also understand that if the information submitted is determined to be false, such determination will result in a denial of providing services as uncompensated services, and that I will be liable for all charges for services provided. No one will be denied medically necessary services for the inability to pay.

Please send the following information along with your completed application:

1. **Proof of Income** – copy of pages 1 & 2 of your current Federal Income Tax
   (If you did not file an income tax return, other acceptable proof of income includes: last 3 months wage stubs, or statement from employer; copy of Social Security benefits; copy of unemployment benefits, etc.)
2. **Denial from Medicaid (**if available)

Complete the following: (* indicates required field(s))

*Patient (full) Name: ______________________________ SS #: ________________

*Address (street): ______________________________

*Address (city/state/zip): ______________________________ *Phone #: ____________

*Employer: ______________________________

*Charity Care Requested by: ______________________________ *Number in household: ______

*Name	*Relationship

If you are seeking charity care for services already rendered by Cuba Memorial Hospital, list the date(s) of service:

____

If you are seeking an eligibility determination for services not yet rendered, check the type of service sought:
☐Emergency Room ☐In-patient ☐Other

List the expected date(s) of Service: ______________________________

I certify that the above information is true and accurate to the best of my knowledge. Further, I will make application for any assistance (Medicaid, Medicare, Insurance, etc.) which may be available for payment of my hospital charge, and I will take any action reasonably necessary to obtain such assistance and will assign or pay to the hospital the amount recovered for hospital charges. If I qualify for a discount program through National Health Services Corps (NHSC) approved sites and sites seeking NHSC-approval and/or rectification, I understand within NHSC-approved sites and sites seeing NHSC-approval and/or recertification, eligibility for sliding scale discounts are based solely on family size and income. No other factor (e.g., assets, Insurance application and/or coverage, citizenship, population type) can be used to assess eligibility. If any information I have given proves to be untrue, I understand that the hospital may re-evaluate my financial status and take whatever action becomes appropriate.

Date of Request: ___________ Applicant's Signature: ______________________________

DO NOT COMPLETE - FOR HOSPITAL PERSONNEL USE ONLY

This document was received on ________________ by ______________________________

The following documents were proved to verify income and family composition.

RETURN ORIGINALS TO PATIENT. ☐Paycheck stubs ☐Income Tax Form ☐Other ____________________