United Health Services
346 Grand Ave
Johnson City, NY 13790
(607) 763-6127

Financial Assistance App Hosp

5800622 - Application for Financial Assistance

Applicant's Name: _____
Address: _____
City: _____ **State:** _____ **Zip:** _____
Telephone: ( ) _____ **Date of Birth:** _____

Family Members *(List spouse and dependent children under 21 years, living in household and their date(s) of birth):*

Name	*Date of Birth*	*Name*	*Date of Birth*
1. _____	/ _____	*4.* _____	/ _____
2. _____	/ _____	5. _____	/ _____
3. _____	/ _____	6. _____	/ _____

Incomplete Applications (Those Missing Any of the Documents Listed Below) Will Be Returned

THE FOLLOWING DOCUMENTATION IS REQUIRED TO DETERMINE ELIGIBILITY:

1. Proof of income:
(submit all documentation that applies to your household)
- ☐ Pay stubs **from last 30 days** for each working member of household.
- ☐ Unemployment printout from website dating back to waiting week. **OR** Workers Compensation statement (2 current stubs).
- ☐ Social Security benefit letter or bank statement if you use Direct Deposit.
- ☐ Proof of monthly pension income.
- ☐ No income.

2. Proof of Health Insurance
Do you have health insurance?
- ☐ YES *(If **YES** attach copy of insurance documents)**
- ☐ NO

3. Other Income Resources:
Do you have any other sources of income?
- ☐ YES *(If YES attach letter with description of income, i.e. rental income, annuity, etc.)**
- ☐ NO

**** Information about other resources is required.***

Discounts are based on family size and income only. UHS does not deny services based on a person's race, creed, color, sex, national origin, sexual orientation, sexual identity, disability, hearing impairment, visual impairment, religion, age, or inability to pay.

I affirm by my signature below that the information contained on this application is true to the best of my knowledge. I agree to provide additional information as requested in order to determine eligibility. I agree to report promptly any changes in my needs, income, living arrangements or address to UHS.

Applicant's Signature: _____

Relationship (if other than patient): _____

Date/Time: _____

OFFICE USE ONLY
Discount % Approved _____ Date Approved _____
Approval Signature _____