BERTRAND CHAFFEE HOSPITAL
FINANCIAL ASSISTANCE PROGRAM

Dear Patient:

Bertrand Chaffee Hospital is proud of its public mission to provide quality of care to all who need it, 24 hours a day, seven days a week, 365 days a year.

If you do not have health insurance or worry that you may not be able to pay in full for your care, we can help. Bertrand Chaffee Hospital provides financial aid to patients based on their income, assets and needs.

It is important that you let us know if you will have trouble paying your bill; federal and state laws require all hospitals to seek full payment of what they bill directly to patients. This means we may turn unpaid bills over to a collection agency, which could affect your credit status.

The program is NOT insurance coverage. If approved by Bertrand Chaffee Hospital, this program is only valid for services provided by Bertrand Chaffee Hospital. You must apply at other facilities in order to be covered elsewhere; not all organizations have these programs.

If approved for this program, the coverage is valid for (6) six months from the date on your application.

In order to complete this process, we may require that you apply for other means of insurance coverage or Medicaid of New York. You must also submit proof of your last three (3) month's income. We require copies of your most recent pay stubs or your unemployment schedule.

If you would like to apply for financial aid, please fill out the attached application and mail it to the address at the bottom of the application with the required supporting documents to the Attention of the Collections Department.

Upon receipt of your completed application your account will be placed on hold for 30 days for internal review. Formal documentation will be forwarded to you with a determination on eligibility and the amount of assistance provided.

If you have any questions regarding what information is required please call 716-592-2871 ext 1207.

We thank you for choosing Bertrand Chaffee Hospital for your healthcare needs.

Sincerely,

Teresa Donohue
Financial Director

BERTRAND CHAFFEE
HOSPITAL

NAME: Last: _____ First: _____ M.I.: _____

ADDRESS: Street: _____ City/State/Zip Code: _____

SOCIAL SECURITY: _____ **HOME PHONE #:** (___) _____

EMPLOYER: _____ **EMPLOYER PHONE #:** (___) _____

	LAST 12 MONTHS	LAST 3 MONTHS X4
PATIENTS GROSS INCOME:	_____	_____
OTHER FAMILY INCOME:	_____	_____
TOTAL FAMILY INCOME:	_____	_____
FAMILY SIZE:	_____	_____

	Patient Income	Other Family Income
Wages		
Social Security payment		
Unemployment		
Disability		
Workers Compensation		
Alimony/Child Support		
Dividends/Interest/Rentals		
All Other Income		
Total		

I affirm that the above information is true, complete, and correct to the best of my knowledge.

Signature: _____ Date: _____

DATE (S) OF SERVICE: _____ ACCOUNT #: _____

If you have any questions or need help completing this application, call (716)-592-2871

EXT: 1207.

ELGIBILITY OF DETERMINATION (FOR OFFICE USE ONLY)

DATE APPLICATON WAS RECEIVED: _____ **INCOME VERIFIED: YES**____ **NO**____

TYPE OF VERIFICATION: _____

The applicant is approved ____/conditionally approved ____ for care at no charge or a reduction of _____% of allowable charges. Amount provided as uncompensated service is _____.

Condition (s) if applicable _____.

DATE OF CONDITIONAL DETERMINATION _____ **DATE OF FINAL DETERMINATION** _____

DATE APPLICANT NOTIFIED _____ **APPROVED BY:** _____

224 East Main Street • Springville, New York 14141-1443
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