BERTRAND CHAFFEE HOSPITAL FINANCIAL ASSISTANCE PROGRAM

224 East Main St Springville, NY 14141

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, and 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 tum 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 approval letter.

In order to complete this process, we may require that you apply for other means of insurance coverage or Medicaid of New.York. You <u>must</u> 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. You can also visit our website at www.bertrandchaffee.com to obtain a copy of the financial aid application. You can also obtain a free copy by mail, by contacting our billing dept. at the number below.

Upon receipt of you 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, Ashley Dash Patients Accts. Manager



NAME: Last:	First:	M.I.:	
ADDRESS: Street:	City/State/Zip	Code:	
	HOME PHONE #: ()		
	EMPLOYER PHONE #: ()		
	LAST 12 MONTHS		
PATIENTS GROSS INCOME:			
OTHER FAMILY INCOME:			•
TOTAL FAMILY INCOME:			
FAMILY SIZE:			
	Patient I	ncome	Other Family Income
Wages	•		The state of the s
Social Security payment			
Unemployment			
Disability Workers Compensation			
Alimony/Child Support			
Dividends/Interest/Rentals			
All Other Income			
Total			
I affirm that the above informat	ion is true, complete, and co	orrect to the best of my l	knowledge.
Signature:			•
orbitatat c.	Date:		
DATE (S) OF SERVICE:	A	CCOUNT #:	
If you have any questions or nee	ed help completing this app	lication call (716) E02	
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EXT: 1207.			•
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	BILITY OF DETERMINATI		
DATE APPLICATION WAS RECE	IVED:	INCOME VERIFIED: Y	ES NO
TYPE OF VERIFICATION:			
**The applicant is approved _	/conditionally approv	ed for care at no c	harge or a reduction of
% of allowable charges.	Amount provided as unco	mnensated service is	**
**Condition (s) if applicable _		**	*
DATE OF CONDITIONAL DETE	RMINATIONDA	TE OF FINAL DETERM	INATION
DATE APPLICANT NOTIFIED _	APPROVED BY:		