The Board of Directors of Niagara Falls Memorial Medical Center has established that the hospital is committed to serving patients whether or not they can pay for part or all of the essential medical care they receive. Further, in no circumstance, shall the hospital ever divert a patient seeking emergency health care based upon ability to pay or source of insurance.

The Financial Assistance Program offers free and discounted fees for inpatient and outpatient hospital services to individuals who meet income and resource guidelines. Income and resource guidelines are based on the current Federal Income Poverty Guidelines. For a copy of these guidelines, please contact the Credit Department at the number below.

Patients (or their designee) must apply for financial assistance within 6 months (180 days) from the date of service. The length of approval for coverage for participation in the Financial Assistance Program is 6 months (180 days). Individuals who were previously denied due to excess income or resources are encouraged to reapply if/when their income status changes.

The following nonessential services are not eligible for financial aid: discretionary, non-reconstructive plastic surgery, convenience items, and non-medically necessary private room accommodations.

A completed application for financial assistance requires verification of income.

Medicaid denials based upon failure to complete an application, or refusal to comply with any conditions of eligibility will result in denial of your request for financial assistance.

The Hospital will refer patients to a facilitated enroller and/or provide preliminary assistance regarding applying for Medicaid, Family Health Plus, and/or Child Health Plus for future health care needs.

Please return the attached application and documentation within 21 days.

Determination of financial assistance eligibility will be made within 30 days of our receipt of the application and proof of income. Applications submitted without proof of income or a letter of explanation will automatically be denied.

Patients (or their designee) must sign that all information provided in the financial assistance application is true. Any approval for patient assistance can be revoked if the application is found to be fraudulent.

During the application and review process, you may disregard bills on which you requested financial assistance.
Application does not guarantee you will receive financial assistance. Please notify the hospital of any changes in your financial situation.

Mail or bring your completed application and copies of verification to:

**Niagara Falls Memorial Medical Center**
Credit Department
621 Tenth Street
Niagara Falls, NY 14301

If you have any questions regarding financial assistance eligibility, please call (716) 278-4568 between 8 a.m. and 4 p.m. Monday through Friday.
FINANCIAL ASSISTANCE APPLICATION

Name: ___________________________ Marital Status: ______________

Spouse's Name: ____________________

Current Address: __________________________

______________________________

Home Phone: ___________________ Cell Phone: ______________

Employer: ________________________ Phone: ______________

Spouse's Employer: ________________ Phone: ______________

Dependent Children/Others that I Support (dependents are people you claim on your income tax):

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Relationship</th>
<th>Lives with Me (Y/N)</th>
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Medical Coverage:

Primary: __________________________ |

Secondary: ________________________

Income Detail:

Gross Salary ____________ Per week () Per month () Annual ()

Spouse Gross Salary ____________ Per week () Per month () Annual ()

Other Income from Legal Dependents ____________ Per week () Per month () Annual ()

Additional Income ____________ From __________________________

*Please include Unemployment compensation, Workers compensation, Social Security, Supplemental Security Income, Public Assistance, Veteran’s payments, Survivor benefits, Pension or Retirement Income, Interest, Dividends, Rents, Royalties, Income from Estates, etc.
Trusts, Education Assistance, Alimony, Child Support, Assistance from outside the household and other miscellaneous sources.

Resource Detail:

Indicate all resources for the family unit.

Bank Accounts:

Checking: $___________
Savings: $___________
Credit Union: $___________
Investments: $___________
Pensions: $___________
Cash Value Life Insurance: $___________
Equity value of real estate (other than primary home): $___________
Other: $___________

DOCUMENTATION

Attach the following information (these may be copies):

- 3 most recent payroll stubs OR
- Most recent tax return
- Unemployment records (if applicable)
- Documentation of government benefits such as SSI, Social Security, or VA Benefits (if applicable)
- Most recent 2 bank statements

The Hospital may request additional documentation to help determine financial assistance eligibility.

I certify that the information I provided is accurate. I understand that this information is subject to verification and I will provide any additional information or documentation the hospital may require.

Signature ___________________________ Date ___________________________

All patient billing and financial information and communication to patients or their designees shall be handled in accord with Hospital policies and in conformance with HIPAA requirements.
For Office Use Only:

Date Received: ________________________________
Final Determination Date: _____________________
Approved: __________________________________
Initials: ___________________________________