Olean General Hospital
A Member of Upper Allegheny Health System
Financial Liaison
515 Main Street • Olean, 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 Olean General 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 Olean General 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 _____ 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**

Complete the following:

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 Olean General 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 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 _____