UPMC
LIFE CHANGING MEDICINE

UPMC Financial Assistance Application Information

UPMC offers financial assistance for medical care provided by UPMC facilities and UPMC affiliated physicians to eligible individuals and families. Based on your financial need, either reduced payments or free care may be available.

You may be eligible for financial assistance if you:

- have limited or no health insurance
- are not eligible for government assistance (for example, Medicare or Medicaid)
- can show you have financial need
- are a resident of the primary service area of the UPMC provider
- provide UPMC with necessary information about your household finances
- have medical bills in an amount that exceeds your ability to pay, as determined by UPMC guidelines

About the Application Process

To apply for UPMC Financial Assistance, please follow these steps:

- Fill out the UPMC Financial Assistance Application form in this packet.
  - > Include the supporting documents listed in the checklist.
  - > Note that you must first explore whether you are eligible for some type of insurance benefits that would cover your care (such as, worker's compensation, automobile insurance, and Medical Assistance). We can help show you how to get the right resources for these.
  - > We then look at your income, assets, and family size to determine the level of assistance available to you. We use a sliding scale, based on federal poverty guidelines.
- We will get in touch with you to let you know if you are eligible for UPMC Financial Assistance.
- We can help you set up a payment plan for any remaining charges or bills that are not covered by UPMC Financial Assistance.

Filing Your Application

Please mail your filled-out application form and copies of your proof of income materials to:

UPMC Financial Assistance
Quantum Building
2 Hot Metal St.
Pittsburgh, PA 15203

Patients of UPMC Kane, UPMC Susquehanna, and UPMC Chautauqua WCA can mail application materials to the appropriate address below:

UPMC Kane
4372 Route 6
Kane, PA 16735
814-837-8585

UPMC Susquehanna
Financial Assistance Office
1205 Grampian Blvd.
Williamsport, PA 17701
1-800-433-0816 or **570-326-8196**

UPMC Chautauqua WCA
Patient Financial Services Department
207 Foote Avenue
Jamestown, NY 14701
1-855-221-0343 or **716-664-0459**

If you have any questions, please call toll-free, **1-800-371-8359**, press option **2**. Additional information is also available on the web at **UPMC.com/PayMyBill**.

UPMC Financial Assistance – Documentation Checklist

Your application must include copies of any of the following documents that apply to you. Please attach copies, not originals, as UPMC can't return any documents sent with the application. If any of the documents are missing, it will delay the processing of your application.

If You Have Income or Assets such as:

- Wages, salaries, tips
- Business income
- Social security income
- Pension or retirements income
- Dividends and interest
- Rent and royalties
- Unemployment compensation
- Workers' compensation income
- Alimony and child support
- Legal judgments
- Cash, bank accounts, and money market accounts
- Matured certificates of deposit, mutual funds, bonds, or other easily convertable investments that can be cashed without penalty

Attach proof of your household income, which may include:

- ☐ Social Security 1099 forms or award letters
- ☐ Unemployment or workers' compensation award letters
- ☐ Pay stubs for the last 30 days
- ☐ Most recent IRS Form 1040 and appropriate schedules
- ☐ If you are self-employed, you must include a full tax return with Schedule C and/or profit and loss statement
- ☐ Support letters
- ☐ Other income, such as trust funds, charitable foundations, etc. (statement from this month or last month)

Attach proof of your assets, which may include:

- ☐ Bank statements, mutual fund statements, money market accounts, COD's, bonds, etc. (statement from this month or last month from all accounts)

If You Have No Income:

- ☐ If you have no income, send us a letter of support. The person who provides your support must sign the letter.

Letter of Denial of Medical Assistance

- ☐ You need to apply for Medical Assistance and send a copy of your Letter of Denial before we can approve your application.

Your Completed and Signed Financial Assistance Application Form

- ☐ Please complete all the parts of the form that apply to you. Note that a separate application must be completed for each individual patient who is requesting financial assistance.

UPMC Financial Assistance – Application Form

Name of Patient:	
Patient's Date of Birth:	Patient's Social Security Number:

Address:		Daytime Phone Number:
City:	State:	Alternate Phone Number:
ZIP:	County:	

Employer's Name:	Spouse's Employer's Name:

Requested Services: Check the services for which you are requesting financial assistance.

These services were provided by (check all that apply):

☐ UPMC Hospitals and Clinics ☐ UPMC Physician Services Division ☐ UPMC Cancer Centers

If you have already received a bill, please give us your account or patient ID number: _____

Do you have health insurance? ☐ Yes ☐ No

Did you apply for Medical Assistance in the past 6 months? ☐ Yes ☐ No

> If yes, please enclose a copy of the Letter of Denial.

Household Information: List ALL members of your household, including dependents, who were on your most recent IRS Form 1040. If your household member has a separate UPMC medical bill that should be considered for financial assistance, please check the box under "UPMC Medical Bill."

Names	Relation to Patient	Age	UPMC Medical Bill
			☐
			☐
			☐
			☐

Total number of household members (including the patient): _____

Monthly Household Income: Give monthly income for yourself and other household members. Also attach copies of your proof of income and asset documents (see documentation checklist).

Monthly Gross Income	**Self**	**Spouse and/or Other Household Members**
Wages/self-employment	$	$
Social Security	$	$
Pension or retirement income	$	$
Dividends and interest	$	$
Rents and royalties	$	$
Unemployment	$	$
Workers' compensation	$	$
Alimony and child support	$	$
Cash	$	$
Bank accounts	$	$
Money market accounts	$	$
Other income	$	$
Total Monthly Family Income	**$**	**$**

Additional Comments:

Disclaimer: I understand that the information I provide will be used only to determine financial responsibility for my charges at UPMC (medical care, including hospital and physician services) and will be kept confidential. I understand that the materials I send to prove my income and assets will not be returned. I further understand that the information which I submit concerning my annual family income and family size is subject to verification by UPMC including, as necessary, obtaining financial information from employers, banks, and other entities listed by me in this application. I understand that if any information I have given is determined to be false, it may result in reversing the financial assistance approval and I will be liable for the full amount of all charges.

My signature authorizes UPMC to verify all information provided on this form. I certify that the above information is true and accurate to the best of my knowledge.

Signature: _____

Relationship to patient: _____

Date: _____