

Application Information

UPMC offers financial assistance for its medical care 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 a UPMC provider
- provide UPMC with necessary information about your household finances

About the Application Process

The process for applying for UPMC financial assistance includes these steps:

- Complete the UPMC Financial Assistance Application form in this packet.
 - > Include the supporting documents listed in the checklist.
 - > We look at your income and family size to determine the level of assistance available to you. We use a sliding scale, based on federal poverty guidelines.
 - > Note that you must first explore whether you are eligible for some type of insurance benefits that would cover your care (for example, worker's compensation, automobile insurance, and Medical Assistance). We can help direct you to the appropriate resources.
- We will contact you to tell you whether you are eligible for UPMC financial assistance.
- We can help you arrange a payment plan for any remaining charges or bills that are not covered by UPMC financial assistance.
 - > A payment plan will consider your financial situation to set payments that you can manage.

Filing Your Application

Please mail your completed application form and copies of your proof of income materials to:

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

If you have any questions, please call toll-free, **1-800-854-1745**, press option 1, then option 6. Additional information is also available on the web at www.upmc.com, select "About UPMC," then "Community Citizenship," and "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 processing of your application.

If You Have Income:

Attach additional 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 three months
- If you are self-employed, you must include a Schedule C and/or profit and loss statement.

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.

FINANCIAL ASSISTANCE

Application Form

Name of Patient: _____

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

Address: _____
Number and Street City State ZIP County

Daytime Phone Number: _____ Alternate Phone Number: _____

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 who were claimed on your most recent IRS Form 1040.

<i>Names</i>	<i>Relation to Patient</i>	<i>Age</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

Monthly Household Income: Give monthly income for yourself and other household members.

Also attach any proof of income documents (see documentation checklist).

	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	\$ _____	\$ _____
Other income	\$ _____	\$ _____
Total Monthly Family Income	\$ _____	\$ _____

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Available Household Resources: Attach copies of your household statements for the last three months to this application.

Do you and other members of your household have a checking account? Yes No

- If yes, you must enclose the last three months' statements.

Give information about your ownership of real estate (homes, property) and vehicles.

Write zero for any of these items that you do not own.

Real Estate Value: \$ _____ Mortgage Balance: \$ _____ Monthly Payment: \$ _____

Other Property: \$ _____ Mortgage Balance: \$ _____ Monthly Payment: \$ _____

Motor Vehicle: Make: _____ Model: _____ Year: _____

Own Lease (check one) Monthly Payment: \$ _____

Motor Vehicle: Make: _____ Model: _____ Year: _____

Own Lease (check one) Monthly Payment: \$ _____

Monthly Household Expenses: Give information about the bills you pay every month.

Mortgage/Rent: \$ _____ Utilities: \$ _____ Real Estate Taxes: \$ _____

Food: \$ _____ Other, please describe: \$ _____

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. 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: _____