FINANCIAL AID APPLICATION

Please check the appropriate box(s) or any area of service that you would like considered for Financial Aid.

- ☐ Geneva General Hospital
- ☐ Soldiers & Sailors Memorial Hospital
- ☐ Geneva General Dermatology
- ☐ Geneva General Cardiology Associates
- ☐ Lifecare Medical Associates
- ☐ Geneva Primary Care
- ☐ Geneva General Surgical Associates
- ☐ Geneva General Anesthesia
- ☐ Clifton Springs Family Medicine
- ☐ Interlakes Orthopaedic Surgery
- ☐ Dundee Family Health Center
- ☐ Seneca Family Health Center
- ☐ Clyde Family Health Center
- ☐ Finger Lakes Gastroenterology
- ☐ Soldiers and Sailors Health Center
- ☐ Finger Lakes Podiatry
- ☐ Urgent Care - Geneva
- ☐ Urgent Care – Seneca Falls

Date of application___________________________________

Patient Information:

Name of Patient:_____________________________________Date of Birth___________________________

Phone (home):______________________________Phone (cell)_____________________________________

Mailing Address: ____
Street Address City State Zip Code

Person responsible for bill____

Visit related account number(s) (if available)____

Household Members:
Please list all household members including minor children under 18 that live with you (even if they are not applying for Financial Aid at his time).

	Name of Household Member	**Date of Birth**
Self		
Other		
Other		
Other		

Household Income:
Please complete the grid below with the type and amount of income for each household member listed above, if applicable.
Please provide copies for support for each type of income listed.

Wages and salary
- One month of current consecutive paystubs

Unemployment benefits
- Unemployment Award Letter or monthly benefit statement

Social Security
- Current year Social Security award letter

Alimony, Disability payments, Workers Compensation payments, Child support, Pension and Retirement distributions, Rental income, all other income received that may apply to you.

Self-declaration of income can be used as a means of verification.

Name of household member	**Type of income**	**Amount of income**	**Indicate yearly/monthly/weekly**

FINANCIAL ASSISTANCE APPROVAL GUIDELINES
2024 INCOME GUIDELINES
The following income guidelines may help determine if you are eligible for Financial Aid.

Family Income as of Percent of the Federal Poverty Guidelines	Equal to or less than 100%	101%-200%	201%- 250%	251%-300%	301%-350%	351%-400%	>400%
Discount Provided	100%	100%	80%	60%	40%	20%	0%
1 person	$15,060	$30,120	$37,650	$45,180	$52,710	$60,240	$60,241
2 person	$20,440	$40,880	$51,100	$61,320	$71,540	$81,760	$81,761
3 person	$25,820	$51,640	$64,550	$77,460	$90,370	$103,280	$103,281
4 person	$31,200	$62,400	$78,000	$93,600	$109,200	$124,800	$124,801
5 person	$36,580	$73,160	$91,450	$109,740	$128,030	$146,320	$146,321
6 person	$41,960	$83,920	$104,900	$125,880	$146,860	$167,840	$167,841
7 person	$47,340	$94,680	$118,350	$142,020	$165,690	$189,360	$189,361
8 person	$52,720	$105,440	$131,800	$158,160	$184,520	$210,880	$210,881
Each additional person add:	$5,380	$10,760	$13,450	$16,140	$18,830	$21,520	

Based on the 2024 Federal Poverty Guidelines for the 48 contiguous states and the District of Columbia located at https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines

I hereby certify that the information contained in this application is complete, true and accurate to the best of my knowledge and belief. I understand that the information contained in this application is given to UR Medicine Finger Lakes Health (including all hospitals and outpatient/affiliated sites) solely to assist them in determining the amount of Financial Aid, and that UR Medicine Finger Lakes Health will consider this information confidential. I understand that UR Medicine Finger Lakes Health may require proof of the information contained in this application, and that the failure to provide reasonable documentation will result in denial of the application. Patients will be evaluated using family size and income.

Responsible Party Signature: ____

Please return this form and all supporting documentation within 20 days of your receipt of this form to:
Geneva General Hospital
Financial Counselor
196 North Street
Geneva, NY 14456

If you have any question or need assistance completing this application, please call our Financial Counselor at 315-787-4150. You do not have to make any payments to the Hospital/Physician Office until you are notified of a decision on your application.