HEALTH REACH
Health Care
for the Homeless

Health Reach Healthcare for the Homeless Program Application

Patient's Name _____ (First) _____ (Last) _____ (MI) _____ (Date of Birth)

Responsible Party _____ (First) _____ (Last) _____ (MI)

Address _____ (Street) _____ (City) _____ (State) _____ (Zip Code)

Phone _____ Household Size _____

Household Information

Please list everyone who lives with you, even if they are not applying for assistance.
Place a √ checkmark before each name below to indicate who is applying for Financial Assistance.

Applying for Financial Assistance	Name	Date of Birth	Relationship to Patient
☐			
☐			
☐			
☐			

Medicaid / Other Insurance Statement

1. I/We ☐ **have /** ☐ **have not** applied for Medicaid, Child Health Plus, or other health insurance to cover these services.
   If not, please explain reason: _____.
2. I/We **have /** ☐ **have not** been approved by Child Health Plus or other health insurance product, with an Effective Date of: _____.
3. I/We **have /** ☐ **have not** received an approval from Medicaid, but with a monthly spend down amount of $ _____.
4. I/We **have /** ☐ **have not** been denied by Medicaid, Child Health Plus, or other health insurance. **Please include a copy of denial with application.**

Mail completed application to:
Regional Health Reach, Attn: Financial Case Manager, 89 Genesee Street Suite 1, Rochester NY 14611

Rev 4/9/20

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*****PLEASE TURN OVER AND COMPLETE PAGE TWO (2) OF THE APPLICATION*****

Types of Income

Wages and Salary
- ☐ Paycheck Stubs
- ☐ Letter from employer on company letterhead, signed and dated
- ☐ Current signed and dated income tax return and all Schedules
- ☐ Business/payroll records

Self-Employment
- ☐ Current signed and dated income tax return and all Schedules
- ☐ Records of earnings and expenses/business records

Unemployment Benefits
- ☐ Award letter / certificate
- ☐ Monthly benefit statement from NYS Department of Labor
- ☐ Printout of recipient's account information from the NYS Department of Labor's website (www.labor.state.ny.us)
- ☐ Copy of Direct Payment Card with printout
- ☐ Correspondence from the NYS Department of Labor

Social Security (Retirement / Disability)
- ☐ Award letter / certificate
- ☐ Annual benefit statement
- ☐ Correspondence from Social Security Administration

Worker's Compensation
- ☐ Award letter
- ☐ Check stub

Child Support / Alimony
- ☐ Letter from person providing support
- ☐ Letter from court
- ☐ Child support/alimony check stub
- ☐ Copy of NY Epicard with printout
- ☐ Copy of child support account information from www.newyorkchildsupport.com
- ☐ Copy of bank statement showing direct deposit

Military Pay
- ☐ Award letter
- ☐ Check stub

Income from Rent or Room/Board
- ☐ Letter from roomer, boarder, tenant
- ☐ Check stub

Interest/Dividends/Royalties
- ☐ Recent statement from bank, credit union or financial institution
- ☐ Letter from broker
- ☐ Letter from agent
- ☐ 1099 or tax return (if no other documentation is available)

Private Pensions/Annuities
- ☐ Statement from pension / annuity

Veteran's Benefits
- ☐ Award letter
- ☐ Benefit check stub
- ☐ Correspondence from Veterans Affairs

Household Income

Proof of income is required. Please write in the amount and type of monies received by all members of the Household listed on Page 1 and attach proof of income with the completed application.

Name of Person	**Type of Income** (see above)	**Gross Income Amount** (Before Taxes)	**Received how often?** (Weekly, Monthly, etc.)

Patient/legal representative's preferred language: _____ Interpreted by (if applicable): _____

I certify the above information is true and accurate to the best of my knowledge. Furthermore, I understand I am encouraged to apply for additional assistance (Medicaid, Medicare, Commercial Insurance, etc.) which may be available for payment of my charges. I will take any action reasonable necessary to obtain such assistance and will assign or pay the amount recovered for charges. If any information I have given proves to be untrue, I understand Regional Health Reach may re-evaluate my financial status and take whatever action becomes appropriate.

Signature of Patient or Responsible Party:
Circle(if phone /telehealth visit): Patient verbalizes that the information provided today over the phone is accurate

_____ (Name) _____ Date

Self-Declaration of Income

If you are unable to provide written verification of income, please complete this section.

I hereby verify that to the best of my knowledge, the above noted income information I have provided is accurate.

Signature of Patient or Responsible Party or Telehealth visit:_____ Date:_____

Approval Signature: _____ Date: _____ ☐ Approved *Circle one:* No Copay $2.00 $4.00 $6.00 Full Responsibility
☐ Not Approved