Business Office/Patient Accounts
Wynn Hospital
111 Hospital Drive, Utica, NY 13502

Fax # 315-801-8746

Together we make a ***difference***.

MV-04-005 Form 1, Rev 7 4/18/24

FINANCIAL ASSISTANCE APPLICATION/DETERMINATION

Patient's Last Name _____First _____MI____ DOB_____

Spouse's Last Name _____First _____MI____ DOB_____

Address _____City/State _____Zip Code _____

Social Security Number _____ (***Optional***) Phone # (Home) _____ (Work) _____

Employer _____

Household Size _____ (number of individuals residing in applicant's home)

	Last 12 Months	Last 3 Months
Patient's Gross Income	_____	_____
Other Family Income	_____	_____
Total Household Income	_____	_____

Include income from wages (last 3 months pay stubs), tax forms for prior year, self-employment, unemployment, social security, pension, compensation, public assistance, alimony, child support, interest, rental dividends, V.A. Benefits, etc.

Is Patient a dependent on any additional tax forms? Yes ☐ No ☐
If yes, please attach copy of Income Tax Return.

Additional Financial Documentation May Be Requested
Please detail any changes in family circumstances or income for the past (6) six months prior to the date of this application and any expected changes in the (6) six months following this application.

To apply for MVHS Financial Assistance Program, please complete this application form within 240 days from date of discharge and provide all required income documentation in relationship to your family size. The MVHS Business Office will make a final written determination of eligibility within (30) thirty working days after receiving the completed application and all required documentation. For the complete version of the MVHS Financial Aid guidelines, please visit our website at mvhealthsystem.org/billing or call (315) 801-3108 or (315) 801-8731 to have a copy sent to you. If you wish to appeal the decision, please contact the Business Office at (315) 801-3108. You may also contact NYS DOH 1(800)-804-5447 or 1(518)-402-6993.

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. I understand that the information, which I submit is subject to verification by MVHS and its Internal auditors.

_____ _____

Date of Request Applicant's Signature