



United Memorial

Medical Center

Quality care right at home.

Application for Financial Assistance

Name _____

Address _____

Phone _____

Cell Phone _____

Family Size/Number in Household _____

Dependent Name	Dependent Age

	Patient Income	Spouse Income
Wages		
Social Security Payment		
Unemployment		
Disability		
Workers Compensation		
Alimony/Child Support		
Dividends/Interest/Rentals		
All other income		
Total		

I affirm that the above information is true, complete and correct to the best of my knowledge.

Signed _____ Date _____

If you have questions or need help completing this application, call Patient Financial Counseling at 585-344-5231

If you have received a bill or bills from the hospital, check here: _____

Please send completed form and attachments to:
United Memorial Medical Center
127 North Street
Batavia, New York 14020