UNIVERSAL PRIMARY CARE

SOUTHERN TIER COMMUNITY HEALTH CENTER NETWORK (716)375-7500 WWW.UPCHEALTH.NET

135 N. UNION ST OLEAN, N.Y. 14760 | 132 WEST MAIN ST CUBA, N.Y. 14727 | 9864 LUCKEY DR HOUGHTON, N.Y. 14744 | 445 BROAD ST SALAMANCA, N.Y. 14779 | 159 INTERSTATE PKWY BRADFORD, P.A. 16701

APPLICATION FOR THE FINANCIAL ASSISTANCE PLAN

Universal Primary Care offers a Sliding Fee Scale to all patients. The Sliding Fee Scale can reduce the cost of services rendered at UPC by between 10-100% and is based on income and family size. If applicable, the sliding fee scale can be used in addition to your health insurance to help with your co-pays and deductibles. To apply, please complete this application including a// requested information.

Patient (full) Name:		Employer:		
Street	City	State	Zip	Phone

Number of Persons in Family: *(including self)*	Household Income Last Twelve (12) Months:	Household Income Last Three (3) Months:

Proof of Income:	
	1040 Tax form from previous tax year
	W2 from Employer for previous year
	Most recent paystubs from current employer (4 stubs if paid weekly, 2 stubs if paid biweekly)
	Social Security Statement of Benefits for current year
	Unemployment benefit statement from the Department of Labor
	Self-attestation of income
	Other:

I certify that the above information is true and accurate to the best of my knowledge. Further, I will make application for assistance (Medicaid, Medicare, Insurance, etc.) which may be available for the payment of my STCHCN charge, and I will take any action reasonably necessary to obtain such assistance and will assign orpay to STCHCN the amount recovered for charges. If any information I have given proves to be untrue, I understand that STCHCN may re-evaluate my financial status and take whatever action becomes appropriate.

Applicant's Signature:___________________________Date of Request________________

****Please send proof of income or self-attestation in with application. Application cannot be processed without the necessary proof of income**

DO NOT COMPLETE- FOR STCHCN PERSONNEL ONLY

This document was received on:______________By:_______________________

Proof of income or self-attestation must be included with application. Return the originals to the patient.

Home information for slide assignment

Head of Home:		
Spouse Name:		
Child's Name:		
Child's Name:		
Child's Name:		
Child's Name:		
Child's Name:		
Child's Name:		
Other dependents:		

***Provide the applicable information for each member of your household. Please note that this information is not used to process your request but, is used only to ensure that your entire family is assigned the appropriate slide reduction. If you do not provide home information, the slide will only apply to the account of the person submitting this sliding fee request. If you have any questions about the sliding fare process, please contact UPC at (716) 375-7500.