Appendix C

13 51 Route 55
Suite 104
LaGrangeville, NY 12540-5137

FINANCIAL ASSISTANCE APPLICATION

Patient Financial Worksheet

Patient Name:_____ Date:_____

Medical Record Number: _____ Accounts:_____

RESPONSIBLE PARTY:

Name: _____ Spouse Name:_____

Address:_____ Address:_____

City/State:_____ City/State:_____

Zip Code:_____ Zip Code:_____

Phone:_____ Phone:_____

Mailing Address (if different from above): _____

HOUSEHOLD INFORMATION

Total number of dependents in household including yourself: _____

Names of dependents_____

_____

Do any other person(s) contribute financially to the family? No_____ Yes $_____(amount)

MONTHLY GROSS INCOME (please indicate all source of income)

Patient/Guarantor:	$_____
Spouse:	$_____
Other Income from legal dependents	$_____
TOTAL GROSS INCOME	$_____

ASSETS (WILL NOT BE CONSIDERED FOR FINANCIAL ASSISTANCE BUT WILL BE USED IF YOU ALSO APPLY FOR MEDICAID)

Savings Accounts:	$_____
Checking Accounts:	$_____
Other bank Accounts:	$_____
Other assets (list)	$_____
	$_____
	$_____
	$_____
	$_____

QUALIFYING MONTHLY INCOME	$_____
QUALIFYING HOUSEHOLD SIZE	_____

I certify that to the best of my knowledge, all answers on this form are true and complete.

Signature:_____Date:_____

Once you have submitted a completed application and required documentation, there is a chance that you may receive a bill in the mail while your application is being processed. You are not responsible for that bill while your application is being processed but please call us at 845-475-9940.