Application for Financial Assistance

Applicant's Name:
Last_____ First_____ MI_____
(please print)
Street Address_____

City_____ State_____ Zip_____ County_____

Social Security Number_____(Optional)

Date of Birth_____ Sex _____ Marital Status_____

Telephone_____

Number of Members in Household_____

Name	Age	Relationship

Employment information:

Applicant Occupation_____

Employer_____ Employer address_____

Employer phone number_____

Spouse/SO Occupation_____

Employer_____ Employer address_____

Employer phone number_____

Income—list income for you, your spouse, and all other household members. Please fill in the estimated gross amount for the last 3 months:

	Patient	Spouse/SO	Other household members
Wages/Income			
Self-Employment Earnings			
Public Assistance			
Social Security			
Unemployment/Workers Comp			
Strike Benefits			
Alimony			
Child Support			
Military Family Allotments/Veterans Benefits			
Pensions			
Income from Dividends			
Interest Income			
Disability			
Other			
Total			

Please attach supporting documentation—paycheck stubs, statements from employers, or other proof of income, such as unemployment, Social Security, etc.

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

Once a completed application has been submitted with supporting documentation you may disregard any bills until the hospital has rendered a written decision on your application. Adirondack Medical Center will not forward any accounts to collection while your application is pending.

Date of Request_____ Applicant's Signature_____

Date Received_____ Financial Counselor Signature_____

Date approved/Denied_____ Prepared by _____

Document checklist

Copy of the application from the enrollment specialist.

Reason for excluded information_____

Proof of residency_____

Reason for excluded information_____

Proof of current gross income--last four pay stubs, WC, disability, VA, child support, alimony, etc.

Reason for excluded information_____

Tax return

Reason for excluded information_____