CLAXTON- HEPBURN MEDICAL CENTER
Financial Assistance Application

Dear CHMC Patient:

Enclosed is an application for financial assistance at Claxton-Hepburn Medical Center. Consideration for financial assistance will apply to eligible services that are considered essential health services provided and billed under Claxton-Hepburn Medical Center. Please be advised that *Essential Health Services* means available medical and dental services and supplies that are considered, by CHMC to be medically necessary for a patient's health. Please review and complete all questions, as the determination for eligibility is based on the information provided.

We will need copies of the following where applicable:

1. List of all household members.
2. Last four (4) consecutive pay stubs or two (2) if paid bi-weekly.
3. Most recent unemployment pay stub.
4. Copy of your award letter from Social Security, retirement, disability etc.
5. Medicaid eligibility status (if available).

In addition to the sliding scale charity care discounts, CHMC offers a 15% discount off charges for uninsured self pay patients who otherwise would not be eligible for any other financial assistance.

Please return the completed application within 30 days to:

Patient Financial Counseling
214 King Street
Ogdensburg, NY 13669

If you do not return the completed application within 30 days with required documentation your request for financial assistance will be denied.

If you have any questions, please contact Patient Financial Counseling at the following numbers:

(315)713-5118
(315)713-5117

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Application Completed By: _____ Date: ___/___/____
(Please Print Name)

Please Mark Line N/A if non-applicable

Patient Name: _____ Date of Birth: ___/___/___
Responsible Person: _____
Spouse/Parent Name: _____
Address: _____ Phone #: Home: ( ) _____
_____ Work: ( ) _____
Cell: ( ) _____
Patient's Employer:_____ Gross Salary: $_____per_____
Spouse's Employer: _____ Gross Salary: $_____per_____
Family Size: _____ # of Dependents: _____
Other income including SSI/Social Security/Child Support payments:
Who receives income: _____ Source_____ Gross amount $ _____per _____
Day Care Cost: _____ Amount paid per child: $_____

Please list all household members including minor children under 21 who live with you (even if they are not applying for Financial Assistance at this time. Use an extra sheet if necessary.)

Name	Date of Birth	Relationship to you	Social Security #

Medicaid Statement:

1. I/We ([ ] have / [ ] have not) applied for Medicaid to cover these services.
    a. If not, please explain why:
2. I/We ([ ] have / [ ] have not) been rejected by Medicaid.
    a. Reason for reject: Include a copy
3. I/We ([ ] have / [ ] have not) been rejected by Child Health Plus or Family Health Plus.
4. I/We received an approval from Medicaid, but with a monthly spend down of $ _____.

I understand that this application for Financial Assistance is confidential and will be used to determine my eligibility for uncompensated services under the Charity Care guidelines established by Claxton-Hepburn Medical Center. If any information that has been given proves to be inaccurate, I understand that Claxton-Hepburn Medical Center may re-evaluate my financial status and take whatever action becomes appropriate.

Signature: _____ **Date:** _____

Approved by: _____ **Date:** _____