Financial Assistance Application

Please Print

Dear Claxton Hepburn Medical 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. Last two (2) bank statements
4. Most recent unemployment or Workman's comp pay stub.
5. Copy of your award letter from Social Security, retirement, disability etc.

In addition to the sliding scale charity care discounts, CHMC offers a 20% 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 <u>with</u> required documentation your request for financial assistance will be denied.

If you have any questions, please contact Patient Financial Counseling at 315-393-3600 Opt 1.

Financial Assistance Application

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Patient's Name_____ DOB: _____

Address: _____City _____State _____Zip Code_____

Phone:_____ Number of dependents in household _____

Household Information

(Please include everyone residing in the household including the applying patient)

Name	**Date of Birth**	**Relationship to Patient**

Income

(Please enter income under appropriate source and enter monthly or dollar amount.)

	Patient	Spouse	Parents (if patient is a child)	Monthly Inc	Annual Inc
Wages				**$**	**$**
Social Security				**$**	**$**
Pension				**$**	**$**
Disability				**$**	**$**
Unemployment				**$**	**$**
Workers Comp				**$**	**$**
VA Benefits				**$**	**$**
Child Support				**$**	**$**
Alimony				**$**	**$**
Rental Income				**$**	**$**
Interest Dividends				**$**	**$**
Other Income				**$**	**$**

I certify that the above information is true and accurate to the best of my knowledge.

Signature _____ Date_____

Upon submitting a completed application, you may disregard any bills until you receive notification of a determination of your application. The applicant will have ninety (90) days from the date of the first statement to request an application And thirty (30) days to submit the completed application. A decision regarding the application will be made within thirty (30) Working days. Applicants will be notified by letter of the decision. Applicants may request a review of denial or partial denial within thirty (30) days from the denial notice. Applicants wishing to appeal the denial may do so by requesting so in writing with additional documentation or any financial or personal situation that they would like taken into consideration.

SELF ATTESTATION OF INCOME

This form should be used by patients who have no other type of documentation to verify their Income.

Please Print

Name: _____ Phone: _____

Address: _____

City: _____State: _____ Zip Code: _____

☐ I GET PAID IN CASH AND DO NOT RECEIVE A PAY STUB

☐ I AM SELF EMPLOYED

Please indicate your gross monthly income: $ _____

I certify that I have no other way to document the above income. I affirm that the income information provided is true, complete and correct to the best of my ability.

Signature: _____ Date: _____