ST LAWRENCE HEALTH
An Affiliate of Rochester Regional Health

Office Use Only	
Patient Account Number:	

FINANCIAL ASSISTANCE APPLICATION

Date of Application: _____

PATIENT INFORMATION

Patient Name	
Patient Date of Birth	
Guarantor Name	
Address	
Home Phone	
Cell Phone	

EMPLOYER INFORMATION

	GUARANTOR/ SELF	SPOUSE
Name		
Address		
Phone		

HOUSEHOLD MEMBERS' INFORMATION

NAME	RELATIONSHIP	DOB
1.	self	
2.		
3.		
4.		
5.		
6.		
7.		

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MONTHLY HOUSEHOLD INCOME

SOURCE	SELF	SPOUSE	*OTHER	TOTAL
Employment (Wages)				0
Self-Employment Income				0
Social Security/Disability				0
Unemployment/Workers' Compensation				0
Pension				0
Dividends/Interest Income/Rental Income				0
Other Income - List Below				
				0
				0
				0
				0
Total Monthly Gross Income	$ 0	$ 0	$ 0	$ 0

RESET TABLE

Please answer the following questions:

	YES	NO	If YES, please explain
Is medical treatment because of a car accident or other third party injury?			
Is medical treatment because of a work related accident or injury?			
Are you applying for Medicaid?			
Have you been approved for Medicaid?			

*Other - anyone for whom you provide more than half of that person's support

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DOCUMENTATION REQUIRED

IDENTIFICATION (one of the following)

1. Driver's License
2. United States Passport or Foreign Passport
3. Alien Registration Card/Work Authorization Card
4. Photo ID
5. Birth Certificate

INCOME (as many as applicable)

1. If employed weekly, last 4 pay stubs.
   If employed bi-weekly, last 2 pay stubs.
2. Last Unemployment Check/Workers' Compensation/NY State Disability Check
3. Prior Year Income Taxes if Self Employed
4. Last Social Security/SSI Check
5. Last Pension Check
6. Other Income

I hereby certify that the information provided above is correct to the best of my knowledge.

_____ _____
Signature of Applicant Date

_____ _____
Signature of Parent/ Guardian Date

Please return the completed form to Patient Financial Advocacy:

Canton-Potsdam Hospital
50 Leroy Street Potsdam,
NY 13676
Tel: 315-261-5476

PRINT SAVE RESET