

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.			

MONTHLY HOUSEHOLD INCOME

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

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**

DOCUMENTATION REQUIRED

IDENTIFICATION (one of the following)

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

INCOME (as many as applicable)

- | | |
|--|--|
| 1. If employed weekly, last 4 pay stubs.
If employed bi-weekly, last 2 pay stubs. | 4. Social Security Award Letter |
| 2. Last Unemployment Check/Workers'
Compensation/NY State Disability Check | 5. 1099 tax form for Pension or Retirement |
| 3. Prior Year Income Taxes if Self Employed | 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:

**St. Lawrence Health
Attn: Financial Advocacy
50 Leroy Street
Potsdam, NY 13676
P. 315.261.5476**