Catskill Regional Medical Center Financial Assistance Application

P.O. Box 800 68 Harris-Bushville Road, Harris NY 12742-0800 (845) -794-3300

Patient Name: _____ Account #: _____

Marital Status_____ Patient SS#:_____ Date of Birth_____ Patient Phone #_____

Home Address: _____

Mortgage: _____ Rent: _____Employer: _____

Bank: _____

I certify that I DO NOT have a ☐**Checking Account** ☐**Savings Account**. Therefore I am unable to provide a statement.

GROSS MONTLY INCOME

Source	**Patient Income**	**Spouse -Significant Other – Parent Income**	**Total Monthly Income**
On/Off the Books			
Self-Employment			
Social Security			
Pension			
Compensation			
Unemployment			
Child Support / Alimony			
Other: Food Stamps, etc.			

List members of your household

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

Important

1. Application must be complete and signed.
2. Return the completed application within 30 days to CRMC at the above address to office of Financial Advocate Unit.
3. Your request will be reviewed after all items are received. You will be notified in writing of our determination within 30 days

Documentation Check List

(1) Driver's license, Passport, or Sheriff's ID. (2) Proof of income (two most recent paystubs, unemployment statement, and/or Social Security statement). (3) Proof of address (rent receipt, utility bill). (4) Two most recent bank statements.

Disclaimer

I have read and understand the above conditions. I also understand that all the information on this application will be verified by the staff at Catskill Regional Medical Center. This document will serve as a release of income verification. I swear all statements in this application are true and correct. Submitting false information will be cause for eligibility denial.

_____ _____

Signature of Applicant **Date**