FINANCIAL ASSISTANCE APPLICATION (PAGE 2)

FAMILY INCOME	MONTHLY AMOUNT List the amounts of your monthly income from all sources. You are required to provide proof of all income from all sources for each family member.
Employment	$
Retirement/Pension benefits	$
Social Security benefits	$
Unemployment benefits	$
Veterans benefits	$
Alimony	$
Rental Property income	$
Military Allotment	$
Self-Employment	$
Other income source	$
Total	$

REQUIRED DOCUMENTS

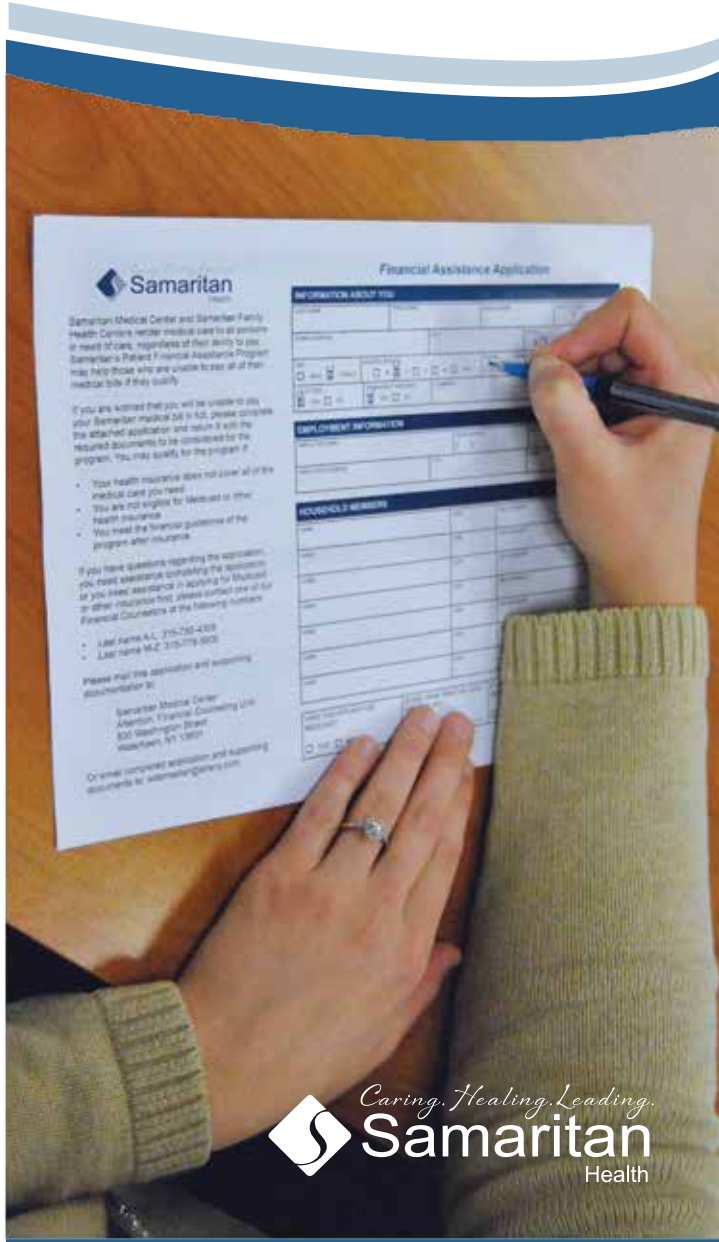
- Eight weeks of current wages, last two bank statements showing current income, or yearly social security statement.
- Medicaid decision letter, applicable.
- Financial assistance application, signed and dated.

I understand that this application for Patient Financial Assistance program is confidential and will be used to determine my eligibility for uncompensated services under the guidelines established by Samaritan Health Systems. I affirm the information provided is accurate to the best of my knowledge. If any information that has been given proves to be untrue, I understand that Samaritan Health Systems may re-evaluate my financial status and take whatever action becomes appropriate.

Applicant Signature _____ Date _____

Applicant Signature _____ Date _____

Patient Financial Assistance Program



Caring. Healing. Leading.
Samaritan
Health

Samaritan Medical Center and Samaritan Family Health Centers render medical care to all persons in need of care, regardless of their ability to pay. Samaritan's Patient Financial Assistance Program may help those who are unable to pay all of their medical bills if they qualify.

If you are worried that you will be unable to pay your Samaritan medical bill in full, please complete the attached application and return it with the required documents to be considered for the program. You may qualify for the program if:

- Your health insurance does not cover all of the medical care you need.
- You are not eligible for Medicaid or other health insurance.
- You meet the financial guidelines of the program after insurance.

If you have questions regarding the application, you need assistance completing the application, or you need assistance in applying for Medicaid or other insurance first, please contact one of our Financial Counselors at the following numbers:

- Last name A-L: 315-785-4308
- Last name M-Z: 315-779-5095

Please mail this application and supporting documentation to:

Samaritan Medical Center
Attention: Financial Counseling Unit
830 Washington Street
Watertown, NY 13601

Or email completed application and supporting documents to: financialassistance@shsny.com

Financial Assistance Application

INFORMATION ABOUT YOU

LAST NAME	FIRST NAME	MIDDLE NAME	DATE OF BIRTH ____/____/____
HOME ADDRESS	CITY	STATE	ZIP CODE
SEX ☐ MALE ☐ FEMALE	MARITAL STATUS ☐ M ☐ S ☐ D ☐ W ☐ UNK	PHONE HOME? CELL? ( ) -	SOCIAL SECURITY NO.
US CITIZEN ☐ YES ☐ NO	PERMANENT RESIDENT ☐ YES ☐ NO	COMMENT	

EMPLOYMENT INFORMATION

EMPLOYER NAME	WORK PHONE ( ) -	OCCUPATION
EMPLOYER ADDRESS	CITY	STATE	ZIP CODE

HOUSEHOLD MEMBERS

NAME	DOB	RELATIONSHIP
NAME	DOB	RELATIONSHIP
NAME	DOB	RELATIONSHIP
NAME	DOB	RELATIONSHIP
NAME	DOB	RELATIONSHIP
NAME	DOB	RELATIONSHIP
NAME	DOB	RELATIONSHIP

HAVE YOU APPLIED FOR MEDICAID? ☐ YES ☐ NO	IF YES, WHAT WAS THE DATE YOU APPLIED? _____/_____/_____	IF YES, WHAT WAS THE DETERMINATION? ☐ APPROVED ☐ DENIED	IF NO, WOULD YOU LIKE TO APPLY? ☐ YES ☐ NO