



## FINANCIAL ASSISTANCE APPLICATION

Please return completed applications to the attention of the Business Office

Date of Request: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

Phone #: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Other Family Members  
(Living at same address)

NAME

RELATIONSHIP

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

### Identify Services for Financial Assistance

*Service(s) received more than 90 days before application will not be considered.*

If you are seeking sliding fee scale aid for services rendered, check service locations below:

Hospital Services:     Emergency Room         Outpatient         Inpatient         Clinic

LIST:	Date of Service	Account Number
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**The following income information is required and must be verified:**

Note: BOTH COLUMNS MUST BE COMPLETED

<b>INCOME: <i>List income for entire family</i></b>	<b>TOTAL FOR LAST 3 MONTHS</b>	<b>TOTAL FOR LAST 12 MONTHS</b>
Wages (includes self-employment)	_____	_____
Social Security	_____	_____
Unemployment Compensation or Workman’s Comp	_____	_____
Alimony/Child Support	_____	_____
Military Family Allotments	_____	_____
Pensions/IRA/Annuities, etc	_____	_____
Income from Rent	_____	_____
Income from Dividends, Interest	_____	_____

**I will furnish, to the best of my ability, proof of the above income categories. I affirm that this statement of family annual income of \$\_\_\_\_\_ is true and accurate to the best of my knowledge, and that all statements made by me in this application are true. I understand that the information is subject to verification by Clifton-Fine Hospital and is subject to review of federal and/or state enforcement agencies and others as required.**

\_\_\_\_\_  
Signature of Person Making Request

\_\_\_\_\_  
Date

**DOCUMENTATION REQUIREMENTS FOR SLIDING FEE APPLICATION**

You must provide proof of eligibility (income verification). If you cannot obtain these items that are applicable to your income, please call and we will assist you in finding out what other documentation may be used to verify your income.

- |                              |  |   |
|------------------------------|--|---|
| <b>Wages and Salary</b>      | <input type="checkbox"/> Paycheck stub (4 consecutive weeks) | <input type="checkbox"/> Dated letter from Employer       |
| <b>Social Security</b>       | <input type="checkbox"/> Award Letter                        | <input type="checkbox"/> Benefit Check                    |
| <b>Self-Employment</b>       | <input type="checkbox"/> Income Tax Return and all Schedules | <input type="checkbox"/> Records of Earnings and Expenses |
| <b>Unemployment Benefit</b>  | <input type="checkbox"/> Award Letter                        | <input type="checkbox"/> Benefit Check                    |
| <b>Alimony/Child Support</b> | <input type="checkbox"/> Letter from Court                   | <input type="checkbox"/> Child Support/Alimony Check stub |
| <b>Workers Compensation</b>  | <input type="checkbox"/> Award Letter                        | <input type="checkbox"/> Check stub                       |
| <b>Evidence of Denials</b>   | <input type="checkbox"/> Medicaid                            | <input type="checkbox"/> Child Health Plus                |
|                              |  | <input type="checkbox"/> Family Health Plus               |

**Applications returned/submitted without documentation will be denied and returned.**