Patient Financial Assistance Program

Clifton-Fine Hospital renders medical care to all persons in need of care, regardless of their ability to pay. Clifton-Fine Hospital'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 Clifton-Fine Hospital 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 our Financial Counselors at the following number:

(315) 848-8000

Please mail this application and supporting documentation to:

Clifton-Fine Hospital
Attention: Business Office; Financial Counseling
1014 Oswegatchie Trail Road
Star Lake, NY 13690

Or email completed application and supporting documents to: lsharrow@cfhis.org

Patient Financial Assistance Program

Financial Assistant Application

Information About You

Last Name:	First Name:	Middle Name:	DOB: _____/_____/_____
Home Address:	City:	State:	Zip Code:
Sex: ☐ Male ☐ Female ☐ Other	Marital Status: ☐ M ☐ S ☐ D ☐ W	Phone: ☐ Home ☐ Cell ( ) -	Social Security No. (optional)
Employer Name:		Comment:	

Household Members

Name:	DOB:	Relationship:	Employed: ☐ Yes ☐ No ☐ Student
Name:	DOB:	Relationship:	Employed: ☐ Yes ☐ No ☐ Student
Name:	DOB:	Relationship:	Employed: ☐ Yes ☐ No ☐ Student
Name:	DOB:	Relationship:	Employed: ☐ Yes ☐ No ☐ Student
Name:	DOB:	Relationship:	Employed: ☐ Yes ☐ No ☐ Student
Name:	DOB:	Relationship:	Employed: ☐ Yes ☐ No ☐ Student

Medicaid Documentation

Have you applied for any of the following to cover these services:(Select all that apply)

☐ Medicaid ☐ Childhealth Plus ☐ Other Health Insurance

If yes, please provide a copy of the notice you received from the Department of Social Services or the New York State of Health

If you have not applied for these programs, would you like to? Yes ☐ No ☐

Patient Financial Assistance Program

Financial Assistance Application (Page 2)	
Family Income	GROSS MONTHLY INCOME 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 Sources:	$
Total	$

Required Income Documents

- Eight weeks of current paycheck stubs
- Current Social Security benefit statement (s)
- Pension Statement of benefits
- Monthly benefit statement (s) for any other income source (s)
- If self-employed, an income attestation and cash flow statement is required

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 Clifton-Fine Hospitals' 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 Clifton-Fine Hospital's Systems may re-evaluate my financial status and take whatever action becomes appropriate.

Applicant Signature: **Date:**