Appendix A

CHARITY CARE APPLICATION
PATIENT FINANCIAL WORKSHEET

Patient Name:___________________________________ **Date:**_______________________________

Medical Record Number:________________________ **Account(s):**_________________________

RESPONSIBLE PARTY:

Name:____________________________________ Spouse Name:______________________________

Address:__________________________________ Address:____________________________________

City/State:_________________________________ City/State:___________________________________

Zip Code:__________________________________ Zip Code:___________________________________

Phone:____________________________________ Phone:______________________________________

Mailing address (If different from above):____

HOUSEHOLD INFORMATION:
Total number of dependents in household including yourself:___________

Do any other person(s) contribute financially to the family? No Yes $_________(amount)

MONTHLY INCOME: (Please indicate all sources of income)

Patient / Guarantor:	$
Spouse:	$
Other Income from legal dependents:	$
Total income:	$

ASSETS (WILL NOT BE CONSIDERED FOR CHARITY CARE BUT WILL BE USED IF YOU ALSO APPLY FOR MEDICAID:

Savings Accounts:____	$
Checking Accounts:____	$
Other bank accounts:____	$
Other assets (list)	$
	$
	$
	$
	$

QUALIFYING MONTHLY INCOME	$
QUALIFYING HOUSEHOLD SIZE	

I certify that to the best of my knowledge, all answers on this form are true and complete.

Signature: ____ **Date:**____________________

Once you have submitted a complete application and the required documentation, there is a chance that you may receive a bill in the mail while your application is being processed. You are not responsible for that bill while your application is being processed but please call us at 914-493-2089.