# Financial Assistance Application

**Directions**:

1. Fill out Application – Page 1.
2. Fill out Income Information Worksheet – Page 2.
3. Attach copy of Medicare, Medicaid and /or Private insurance cards – front and back if applicable.
4. Please return application within 30 days to the office or mail to:

St. Joseph's Physician Health, PC
Financial Assistance Program
PO Box 2337
Syracuse, N.Y. 13220

Date: _____

Patient Last Name: _____ First Name: _____ MI: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

County: _____ Home Ph.: _____ Cell Ph.: _____ E-mail: _____

Guarantor/responsible party (If patient under 18): _____

**Insurance Information**:

____No Insurance

Medicare #: _____ Effective Date: _____

Medicaid #: _____ Type of Coverage*: _____ If Spend down, list amount: $_____/quarter
*Continuous, Spend down, General relief, QMB

Have you applied for Medicaid YES NO (circle one) If not, why: _____

Other Insurance 1: _____ Policy # _____ Effective Date: _____

Name of Policyholder: _____ Type of Coverage*: _____
*Hospital/Medicare Tie-in/Drugs/Inpatient/Outpatient/prescription card)

Other Insurance 2: _____ Policy # _____ Effective Date: _____

Name of Policyholder: _____ Type of Coverage*: _____
*Hospital/Medicare Tie-in/Drugs/Inpatient/Outpatient/prescription card)

## Financial Assistance
## Income Information

Number of Dependents: _____ (as shown on your Federal Income Tax Form). If you do not file taxes, indicate the number of persons you support or who support you.

List yourself and all members of your household. Write N/A in columns for those with no income.

| Name | Age | Relationship | Adjusted Gross income<br>Listed on most recent 1040 tax return. | Other Sources of Income<br>Disability, Veterans Benefits, Unemployment, AFDC, Workers Compensation. |
|---|---|---|---|---|
| 1. | | | $ Month | $ Month |
| 2. | | | $ Month | $ Month |
| 3. | | | $ Month | $ Month |
| 4. | | | $ Month | $ Month |
| 5. | | | $ Month | $ Month |
| 6. | | | $ Month | $ Month |
| 7. | | | $ Month | $ Month |
| Total | | | $ Month | $ Month |