Orleans Community Health
Financial Assistance Application

Patient Name: ____________________________________ **Date of Birth:** ____________________________

Address: ____

Number/Street *City* *State* *Zip*

Contact Telephone Numbers: (*Please provide all applicable contact numbers)*

Home: _______________________ **Work:** ____________________ **Cell:** ________________________

Family Size: ______________ **Occupation:** ____

Current Employer: ____

The following income information is mandatory for application to be reviewed. List all forms of income, both earned and unearned for all family members listed on the application. Family members include only those listed on the Federal Tax Return.

***Note: Based on review of income you may be asked to submit Medicaid status information**

INCOME: LIST GROSS INCOME FROM FAMILY (EXPENSES ARE NOT INCLUDED)	TOTALS FROM LAST 12 MONTHS	INCOME: LIST GROSS INCOME FROM FAMILY (EXPENSES ARE NOT INCLUDED)	TOTALS FROM LAST 12 MONTHS
WAGES (INCLUDES SELF-EMPLOYMENT) last 4 consecutive paystubs		PUBLIC ASSISTANCE	
SOCIAL SECURITY YEARLY BENEFIT LETTER		MILITARY FAMILY ALLOTMENTS	
UNEMPLOYMENT COMPENSATION		WORKER'S COMPENSATION	
ALIMONY/CHILD SUPPORT		INCOME FROM DIVIDENDS, INTEREST	

Please List Other Family Members

NAME	RELATIONSHIP	DATE OF BIRTH

*Note: INCOMPLETE APPLICATION WILL BE RETURNED UNPROCESSED

I certify that the information is true and accurate to the best of my knowledge. I understand that this application is made so that Orleans Community Health can judge my eligibility for Charity Care benefits as related to New York State Charity Care Guidelines.

____ ______________________

Signature *Date*

Please send completed application by fax to (585)798-8444
or by mail to: Orleans Community Health, Attn: Patient Accounting Department, 200 Ohio Street, Medina, NY 14103
or drop application off at Medina Memorial Hospital switchboard or business office