

**Financial Counseling**

730 S Crouse Ave, Suite 204, Syracuse, NY 13210

Phone (315) 470-5825 Fax (315) 470-2919

www.crousemed.com

***Financial Assistance Application***

**Applicant’s Information**

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Applicant’s, Parent, Guardian Name Social Security Number DOB: Mo Day Year Preferred Language

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Applicant’s Home Address City State Zip Code

( ) - ( ) -

Cell, Home, Work Phone Number Cell, Home, Work Phone Number Email Address

**Patient’s Information**

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Applicant’s, Parent, Guardian Name Social Security Number DOB: Mo Day Year

Patient’s Relationship to Applicant: ⃣ Self ⃣ Spouse/Partner ⃣ Parent/Legal Guardian ⃣ Child ⃣ Other:

 Please Specify

Approximate Date of Service: Account Number(s):

**Total Household Size: List the dependents who reside in the applicant’s house for which the applicant takes financial responsibility. Check the appropriate box for each dependent.**

**Name Age Relationship**

 Spouse/Partner Parent Child Other

1. ⃣ ⃣ ⃣ ⃣

2. ⃣ ⃣ ⃣ ⃣

3. ⃣ ⃣ ⃣ ⃣

4. ⃣ ⃣ ⃣ ⃣

5. ⃣ ⃣ ⃣ ⃣

 Total **GROSS** Monthly Income for the last 30 days:

|  |  |  |
| --- | --- | --- |
| **Sources of Income** | **Applicant/Patient** | **Spouse/Live-in Partner** |
| Wages | $ | $ |
| Social Security Payment | $ | $Please provide copies of checks, paystubs, or statements to support all reported income. |
| Unemployment Compensation | $ | $ |
| Disability Payment | $ | $ |
| Workers Compensation | $ | $ |
| Alimony/Child Support | $ | $ |
| Dividends, Interests, Rental Income | $ | $ |
| Other | $ | $ |

⃣ **I allow a health insurance representative to contact me to assist me in applying for government sponsored health insurance.**

**Best time to be reached:**  ⃣ **Morning** ⃣ **Afternoon** ⃣ **Evening** ⃣ **Weekend** ⃣ **Anytime**

**I certify that the information and documentation provided and that the answers given are truthful and accurate. My failure to pay any reduced or adjusted balance will subject me to the normal billing and collection practices of Crouse Health.**

 / / **X**

Date Time Applicant/Patient Signature (Parent/Legal Guardian for minor child)