LOURDES

PATIENT FINANCIAL ASSISTANCE PROGRAM APPLICATION

Applicant's Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Telephone: ( ) _____ **Date of Birth:** _____

Family Members *(List spouse and dependent children under 21 years, living in household and their date(s) of birth):*

Name	*Date of Birth*	*Name*	*Date of Birth*
1. _____	/ _____	5. _____	/ _____
2. _____	/ _____	6. _____	/ _____
3. _____	/ _____	7. _____	/ _____
4. _____	/ _____	8. _____	/ _____

APPLICANTS MUST SUBMIT ALL RELEVANT DOCUMENTS IN THE SAME MAILING.

THE FOLLOWING DOCUMENTATION IS RECOMMENDED TO DETERMINE ELIGIBILITY:

1. Proof of Income: ***(submit all documentation that applies to your household)***

- ❑ Pay stubs **from last 30 days** for each working member of household.
- ❑ Unemployment printout from www.labor.ny.gov dating back to waiting week. If Workers Compensation, proof of the last 30 days of payments.
- ❑ Social Security benefit letter or official bank statement (all pages).
- ❑ Pension statement.
- ❑ Self Employed – Please provide completed Self Declaration of Income.

2. Proof of No Income:

- ❑ No Income – Please provide a written statement explaining how your needs are being met.
- ❑ No Proof of Income – Provide completed self-declaration of income.

3. Other Income

Do you have any other sources of income?

- ❑ YES ***(If YES provide proof of income for rental income, annuities, etc.)***
- ❑ NO

4. Proof of Health Insurance

Do you have health insurance?

❑ YES ***(If YES attach copy insurance cards)*** ❑ NO

I affirm by my signature below that the information contained on this application is true to the best of my knowledge. I agree to provide additional information as requested in order to determine eligibility. I agree to inform Lourdes promptly of any changes in my needs, income, living arrangements or address.

✗ _____
Applicant's Signature

✗ _____
Relationship *(if other than patient)*

✗ _____
Date

OFFICE USE ONLY

Discount % Approved _____ Date Approved_____

Approval Signature _____

MAIL APPLICATION TO:

Lourdes Hospital
Patient Financial Assistance Program
169 Riverside Drive
Binghamton, NY 13905

Phone: (607)584-5522

www.LOURDES.com

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