



Auburn Community Hospital  
Financial Assistance Application

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Family size / number in household \_\_\_\_\_

	Patient Income	Spouse Income
Wages (last 2 paystubs)		
Social Security payment (Include bank statements)		
Unemployment		
Disability		
Workers compensation		
Alimony/child support		
Dividends/interest/rentals		
All other income		
<b>Total</b>		

I affirm that the above information is true, complete, and correct to the best of my knowledge.

Signed \_\_\_\_\_ Date \_\_\_\_\_

If you have received a bill or bills from the hospital, check here: \_\_\_\_\_

You do not have to make any payment to the hospital until the hospital sends you a letter with its decision on your application.

If you have questions or need help completing this application, call **Lisa Gasparro at (315) 255-7210**. Please send completed form and attachments (copy of photo ID, proof of address, documents listed above) to:

ACH Financial Services  
Dept. Auburn Community  
Hospital 17 Lansing Street  
Auburn NY 13021

*If you have any concerns regarding this financial assistance process, please contact our Patient Advocate, Christine DeProspero at (315) 255-7166 Monday-Friday between the hours of 7am-3pm.*