AUBURN COMMUNITY HOSPITAL

Financial Assistance Application

Patient Name: _____ MRN (if known): _____
First MI Last

Social Security Number: _____ Date of Birth: _____

Cell Phone Number: _____ Other Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Is this Applicant (above) the Guarantor? ❒ Yes ❒ No If no, Guarantor Name: _____

Guarantor Address: _____

Household Members				
Household Member Name	**Relationship**	**Applying?**	**Date of Birth**	**Social Security Number**
		❒ Yes ❒ No		
		❒ Yes ❒ No		
		❒ Yes ❒ No		
		❒ Yes ❒ No		
		❒ Yes ❒ No		
		❒ Yes ❒ No		

Earned Income: *Income such as Salary, Wages, Self Employment*			
Household Member Name	**Employer**	**Amount**	**Period**

For Office Use: Gross Household Earned Income – Total(s): Monthly - _____ *Annually -* _____

Unearned Income: *Income such as Social Security Payment(s), Unemployment, Disability, Workers Compensation, Alimony, Child Support, Dividends or Interest, Rental Income, Other*			
Household Member Name	**Unearned Income Type**	**Amount**	**Period**

For Office Use: Gross Household Unearned Income – Total(s): Monthly - _____ *Annually -* _____

Is anyone in the household already enrolled in Medicaid or Medicare? ❒ Yes ❒ No

Is anyone in the household currently covered by a private/company/other insurance plan? ❒ Yes ❒ No

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

PATIENT SIGNATURE: _____ SPOUSE SIGNATURE: _____

GUARANTOR NAME: _____ _____
(If other than patient) (Please Print) (Relationship to Patient)

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

If you know your visit-related account numbers please note them here:

Date of Service	Account Number	Date of Service	Account Number	Date of Service	Account Number	Date of Service	Account Number

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.

* *document examples*

Proof of Address:
- Bill from Hospital
- Other Bills to your Address ie) Phone Bill, Electric Bill,
- Bank Statements

Proof of Identity (US Citizenship):
- Driver's License
- Passport (US or Foreign)
- State Photo ID Card/Government Issued ID Card
- Birth Certificate only if needed, must be accompanied by some photo-id

Proof of Income:
- Pay Check Stubs (2 bi-weekly or 4 weekly)
- Bank Statements
- Profit & Loss Statement (self employment)
- Social Security or other Assistance Payment Letter
- Unemployment Benefits Letter
- Worker's Comp. Statement/Letter

Proof of Residency for Non-US Residents:
- Green Card
- Permanent Resident Status Card
- Other Residency document issued by the federal government, subject to approval