St. Mary's Healthcare
Amsterdam

Dear Patient/Applicant,

The team at St. Mary's Healthcare is committed to minimizing the financial barriers to healthcare that may exist to our patients and community members. Financial assistance is offered for emergency and other medically necessary care provided to patients who qualify. We are sending this letter along with the attached financial assistance application because you have open balances and you may benefit from our Financial Assistance Program.

If interested, please complete the application. Along with the application, you will need to provide a copy of at least one of the following items as your proof of income. If you are married, your spouse will also need to provide a copy of at least one of the following items as proof of their income before the application can be processed.

- Copies of three (3) most recent paystubs from employer(s)
- Social Security and/or Pension Retirement Letter
- Copy of receipt of unemployment benefits
- Other income validation documents

Please know that the completed application along with proof of income must be received for the application to be considered. We are unable to process or consider applications that are not complete.

Please mail your completed application and documentation to the following address:

St. Mary's Healthcare

ATTN: Patient Financial Services

427 Guy Park Ave

Amsterdam, NY 12010

If you have any questions about the application, please contact our Patient Financial Services team at 518-770-7567.

Thank you for trusting us to care for you and your family's healthcare needs.

Sincerely,

Patient Financial Services
St. Mary's Healthcare

Financial Assistance Application

Applicant Information:

(Please print, and all fields must be completed. Indicate N/A if not applicable on any individual line in the application.)

Name (first and last) ____
Birth date _________________ Phone #_________________________
Mailing address__________________________________ City____________ State_______ Zip___________
Employer___________________________Employment status___________ Number of hours worked per week______

Applicant's Spouse Information:

Name(first and last)____
Birthdate______________ Phone #______________________
Employer_________________________Employment status______ Number of hours worked per week________

Dependents:

Name_______________________________ Birthdate________ Relationship___________
Name_______________________________ Birthdate________ Relationship___________
Name_______________________________ Birthdate________ Relationship___________
Name_______________________________ Birthdate________ Relationship___________

Monthly Income:

(Fill on dollar amounts for each item below. Provide amounts per month for each.)

Applicants gross Income_________________
Spouse Gross Income___________________
Social Security Benefits ________________
Pension/Retirement Income_______________
Disability Income________________________
Workers Comp Income ___________________
Child Support Received____________________
Alimony Received ________________________
Rental Property Income____________________
Self Employment Income___________________
Other Income________________
No Income: Complete/sign Declaration of no income

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 to determine eligibility. I agree to inform St Mary's Healthcare promptly of any changes in my needs, income, living arrangements or address.

____
Applications signature

____
Relationship (if other than patient)

____
Date

OFFICE USE ONLY
Discount % Approved_______
Date Approved____________
Approval Initials____________

St. Mary's Healthcare Amsterdam

DECLARATION OF NO INCOME

This form should only be used by patients who have no source of income to explain how they support themselves and others dependent on them.

Name: ______________________ Phone: ______________________

Address: ______________________

City, State, Zip: ______________________

Please explain below how your needs are being met:

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____

Last employment date: (MM/YY) ______________________

Last employer: ______________________

I certify that I have no other way to document the above information and that all of the above information is true and accurate. I understand that this information is to be used to determine eligibility for financial assistance. I agree to inform St Mary's Healthcare promptly of any changes in my needs, income or address.

Signature: ______________________ Date: ______________________