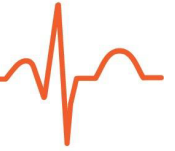




Clifton Park & Halfmoon Emergency Corps Inc.

15 Crossing Blvd. • Clifton Park, NY 12065 • (518) 371-3880 • www.cphmems.org



Charity Care Payment Application

The Clifton Park & Halfmoon Emergency Corps Charity Care Payment Program helps patients and families who are unable to pay all of their medical bills related to services.

You may qualify for a discount through the Charity Care Payment Program if:

- You do not have health insurance
- You are not eligible for Medicaid or some other type of insurance
- You meet the financial hardship criteria

If you have any questions about completing this form, please call (518) 371-3880

Patient Name: _____ **Date of Birth:** _____

Social Sec. #: _____ - _____ - _____ **Date of Service:** _____

Patient's Name/Address: _____

Phone#: _____

Responsible Party's Name/Address: _____

Such as parent, guardian, or power of attorney

Phone#: _____

Number of People in the household: _____

Charity Care is based on total Gross Income of the household, please list all sources of income.

(Please include copy of wage statement/pay stubs for the past 2 pay periods)

Employer and address: _____

Pre-Tax Salary: \$ _____ **per week** _____

Employer and address: _____

Pre-Tax Salary: \$ _____ **per week** _____

Employer and address: _____

Pre-Tax Salary: \$ _____ **per week** _____

Other Income: **Child Support** \$ _____ per month
 Disability \$ _____ per month
 Alimony \$ _____ per month
 Unemployment \$ _____ per month
 Other \$ _____ per month

Please include copy of previous year's tax return of responsible party.

If patient is claimed as a dependent on someone's tax return, include that tax information also.

INSURANCE STATEMENT: (Please check all that apply. Attach copies of all notices)

1) Have / Have Not applied for Medicaid to cover these services. If not, please explain reason:

2) Have / Have Not been rejected by Medicaid. Reason for rejection:

3) Have / Have Not applied insurance through the Health Care Exchange (www.healthcare.gov)

General Comments and Additional Considerations:

I understand that the information that I provide to Clifton Park & Halfmoon Emergency Corps is confidential and will be used to determine my eligibility for uncompensated services under the Charity Care Payment guidelines established.

Completed By: _____ Relationship: _____

Signature of patient or responsible party: _____ Date: _____

Please do not forget to include all supporting documentation

Please return completed form to: Clifton Park & Halfmoon Emergency Corps Inc.
 15 Crossing Blvd.
 Clifton Park, NY 12065