CROUSE HEALTH
Affiliate of Northwell Health

Financial Counseling
736 Irving Avenue, Syracuse, NY 13210
Phone (315) 470-7030 Fax (315) 470-2624
www.crouse.org

Financial Assistance Application

Applicant's Information

_______________________________ _______/_______/_______ DOB: _______/______/_____ ______________________
Applicant's, Parent, Guardian Name | Social Security Number | DOB: Mo Day Year | Preferred Language

____ ______________________, ____________ ____________
Applicant's Home Address | City | State | Zip Code

(_______) ___________-___________ (_______) ___________-___________ ______________________________
Cell, Home, Work Phone Number | Cell, Home, Work Phone Number | Email Address

Patient's Information

_______________________________ _______/______/_______ DOB: _______/______/_______
Applicant's, Parent, Guardian Name | Social Security Number | DOB: Mo Day Year

Patient's Relationship to Applicant: ☐ Self ☐ Spouse/Partner ☐ Parent/Legal Guardian ☐ Child ☐ Other: ______________________
Please Specify

Approximate Date of Service:______________________ Account Number(s):______________________

Total Household Size: List the dependents who reside in the applicant's house for which the applicant takes financial responsibility. Check the appropriate box for each dependent.

Name	**Age**	**Relationship** Spouse/Partner	Parent	Child	Other
1. ______________________	________	☐	☐	☐	☐
2. ______________________	________	☐	☐	☐	☐
3. ______________________	________	☐	☐	☐	☐
4. ______________________	________	☐	☐	☐	☐
5. ______________________	________	☐	☐	☐	☐

Total **NET** Monthly Income for the last 30 days:

Sources of Income	**Applicant/Patient**	**Spouse/Live-in Partner**
Wages	$	$
Social Security Payment	$	$
Unemployment Compensation	$	$
Disability Payment	$	$
Workers Compensation	$	$
Alimony/Child Support	$	$
Other	$	$

Please provide copies of checks, paystubs, or statements to support all reported income.

☐ **I allow a health insurance representative to contact me to assist me in applying for government sponsored health insurance.**

Best time to be reached: ☐ **Morning** ☐ **Afternoon** ☐ **Evening** ☐ **Weekend** ☐ **Anytime**

I certify that the information and documentation provided and that the answers given are truthful and accurate. My failure to pay any reduced or adjusted balance will subject me to the normal billing and collection practices of Crouse Health.

_______/_______/_______ ____________ X______________________________________
Date | Time | Applicant/Patient Signature (Parent/Legal Guardian for minor child)

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