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

Patient's Information

______________________ ____/____/____ DOB: ____/____/____ ______________________
Patient 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

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**	Spouse	Parent	Child	Other
			Relationship		
1. ______________________	______	☐	☐	☐	☐
2. ______________________	______	☐	☐	☐	☐
3. ______________________	______	☐	☐	☐	☐
4. ______________________	______	☐	☐	☐	☐
5. ______________________	______	☐	☐	☐	☐

Total **NET** Annual Income:

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)