Cayuga HEALTH SYSTEM

FINANCIAL ASSISTANCE PROGRAM APPLICATION

Patient Sticker

Date: _____

Patient's Name: _____ Date of Birth: _____

Address: _____ Telephone: _____

Date(s) of Medical Care: _____

Location of Medical Care: ☐ CMC ☐ CMA ☐ Schuyler

Health Insurance Company: _____

Employer (self): _____ (spouse): _____

Can you be named as a dependent by anyone else? ☐ Yes ☐ No
If yes, you must include income information on that person and all dependents of that person.

List total number of dependents in your household as defined by the I.R.S.

Dependent Information: (attach extra sheet as necessary)	
Name:	**DOB:**
Name:	**DOB:**
Name:	**DOB:**
Name:	**DOB:**

Status of Applications:

Medicaid:	☐ have not applied	☐ pending	☐ denied (attach copy)
Child Health Plus:	☐ have not applied	☐ pending	☐ denied (attach copy)
Other Governmental Plans:	☐ have not applied	☐ pending	☐ denied (attach copy)

Monthly Income: (please include all income from all individuals in your household)

Monthly GROSS Household Income:	$ _____	Please attach pay stubs for the most recent 3 month period.
Monthly Interest / Dividends:	$ _____	Please provide copies of most recent statements
Monthly Child Support / Alimony:	$ _____	Please provide supporting documentation
Monthly Pension / Social Security:	$ _____	Please provide copies of most recent statements
Monthly Rental / Other Income:	$ _____	Please provide supporting documentation

I affirm by my signature below that the information contained in this applications is true to the best of my knowledge. I agree to provide additional information as requested in order to determine eligibility. I agree to promptly inform Cayuga Health System of any changes in my needs, address, or a change in my income of $5,000 or more. I agree to allow Cayuga Health System to use the information on this application to determine my financial assistance eligibility at all participating providers.

Applicant's Signature: _____ Relationship: _____

Mail Completed Application to your location of Medical Care:

Cayuga Medical Center
Patient Accounting
Attn: Financial Assistance
101 Dates Drive
Ithaca, New York 14850
(607) 274-4400

Cayuga Medical Associates
Attn: Financial Aid
1301 Trumansburg, Rd
Suite P
Ithaca, New York 14850
(607) 882-0010

Schuyler Hospital
Attn: Financial Counselor
220 Steuben Street
Montour Falls, New York 14865
(607) 535-8671 or (607) 535-8600

For use by Cayuga Health System ONLY: ☐ CMC ☐ Schuyler ☐ CMA
☐ Approved at _____% ☐ Denied ☐ Pended Date: _____
If Initially pended: Final Determination Approved at _____% ☐ Denied