



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 B
 Ithaca, New York 14850
 (607) 882-0010

Schuyler Hospital
 Attn: Financial Counselor
 220 Steuben Street
 Montour Falls, New York 14865
 (607) 535-8621 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

02025 (04/28/22)

