

Albany Memorial/Samaritan Hospitals

Patient Accounting
600 Northern Blvd, Albany, NY 12204
(518) 471-3606 fax (518) 471-3254

Primary Care Network

Primary Care Billing
600 Northern Blvd, Albany, NY 12204
(518) 471-3610 fax (518) 427-3314

Financial Assistance Application

Patient Name: _____
(First) (MI) (Last) (Suf)

Social Security No: _____ - _____ - _____ Date of Birth: ____/____/____

Address: _____ Home Phone: (____) - _____ - _____

City: _____ State: _____ Zip Code: _____

Spouse's Name: _____ Spouse's SS#: _____ - _____ - _____

Parent/Guardian: _____ SS#: _____ - _____ - _____

(Required if Patient is a minor under the age of 18)

Dependent (children) names(s) & relationship: _____ Date of Birth: ____/____/____

Employer Name: _____ Spouse's Employer: _____

Gross Income: List all Sources (Parental income required if patient is a minor)

Sources	Patient/Parent	Circle one	Spouse/Parent	Circle one
Wages/Unemployment benefits		Wk/biwk/month		Wk/biwk/month
Social Security/Disability		Wk/biwk/month		Wk/biwk/month
Workers Compensation		Wk/biwk/month		Wk/biwk/month
Alimony/Child Support		Wk/biwk/month		Wk/biwk/month
Dividends/Interest/Rentals		Wk/biwk/month		Wk/biwk/month

If no income, when was the last time you had income? _____

If no income, how are you supporting yourself? _____

AFFIRMATION: I affirm that the above information is true to the best of my knowledge. I agree to provide additional information as requested in order to determine eligibility. I agree to inform Northeast Health promptly of any change in my needs, income, living arrangements, or address. I also understand that providing incomplete documentation or false information with this application will result in a denial of my eligibility for reduced charges and that I will be responsible for the full cost of services provided by the hospital. * By submitting this financial aid application I hereby authorize Samaritan Hospital/Albany Memorial Hospital to access my credit report, which will only be used to make a determination as to my eligibility for the Hospital's financial aid program

Signature: _____ Date: ____/____/____
(required)

Please explain below any unusual financial circumstances, which would assist us in evaluating this request:

Application Processing:

1. Financial Assistance applications must be requested within **90** days of discharge date. Upon receipt of our application patient shall have **20** days to complete and return to our Patient Accounting Department.
2. The Hospital will respond in writing with a final determination within **45** days of receipt of a completed application.
3. While your application is being processed, you do not have to make any payment to the Hospital until we send you a letter with our decision on your application. Our representatives from Cardon Healthcare, who assist the Hospital in evaluating your application, may contact you. If contacted by Cardon, failure to respond will result in a denial of your application.

If you have any concerns or issues you are unable to resolve with the Hospital you may call the New York State Department of Health at **1-800-804-5447**.

Please send completed form to:

**Attn: Patient Accounting
Albany Memorial Hospital
600 Northern Blvd
Albany, NY 12204**

Or

**You may also FAX this application to:
518-471-3254**