

Columbia Memorial Hospital Uncompensated Care Application

Date of Application: _____

Patient Name: _____

Date of Birth: _____

Social Security Number: _____

Home Telephone#: _____

Street address/PO Box: _____

City, State and Zip Code: _____

Dates and Type of Services for Which I am Applying:

A. Inpatient: Date: _____ **Account #:** _____

B. Outpatient: Date: _____ **Account #:** _____

General Information:

A. Family Size: _____ *A family is established by those who are married, or claimed as a dependent on another's tax return.*

B. Gross Family Income: _____ *Indicate if weekly, monthly, etc for each source of income received*

	Type of Income	Dollar Amount	How often received
1.	Wages	_____	_____
2.	Unemployment	_____	_____
3.	Child Support	_____	_____
4.	Workers Compensation	_____	_____
5.	Social Security	_____	_____
6.	Public Assistance	_____	_____
7.	Other	_____	_____

C. Outstanding Medical Bills: _____.

D. Liquid Assets: *List all liquid assets; E.I.; bank accounts, available cash, and stocks & bonds*

	Type of Asset	Dollar Amount
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

In order to process the application the below information is required

Please check if included

- 1. *Last three copies of your paycheck stubs (if applicable)*
- 2. *Most recent copy of your social security check (if applicable)*
- 3. *Copy of previous tax return*
- 4. *Proof of residency in Columbia, Greene, Dutchess County*
- 5. *Medicaid Denial*
- 6. *Current copies of your medical bills may be requested*

If you were not required to file an income tax return this year, please sign the below affidavit attesting to this:

Signature

Date

I certify that the above information is true and correct and I understand that the information submitted is subject to verification by Columbia Memorial Hospital and audits as required.

Signature

Date

Please keep Columbia Memorial Hospital informed of application process at all times. Failure to do so could result in your account(s) being relinquished to a collection agency. In this instance the application would become null and void. Please refer all questions and concerns to our Patient Accounting Department, which can be reached Monday-Friday 8:00am-4:00pm at 518-828-8064.

Please return completed application to: Columbia Memorial Hospital
71 Prospect Ave
Hudson, NY 12534
Attention: Patient Accounts Department

Date Approved: _____

Approved By: _____

Percentage Approved: _____