



APPLICATION FOR FINANCIAL ASSISTANCE PROGRAM

Financial Liaison
529 Central Ave • Dunkirk, NY 14048
(716) 363-7221 • Fax (716) 363-7356

Date of Request: _____

Request for Determination of Eligibility for Financial Assistance Program

I hereby request that Brooks Memorial Hospital make a written determination of my eligibility for the Financial Assistance Program. I understand that the information requested below concerning my annual income and family size is subject to verification by the Brooks Memorial Hospital. I also understand that if the information submitted is determined to be false, such determination will result in a denial of providing services as uncompensated services, and that I will be liable for all charges for services provided. No one will be denied medically necessary services for the inability to pay.

Please send the following information along with your completed application:

- 1. Proof of Income – copy of pages 1 & 2 of your current Federal Income Tax
2. Denial from Medicaid (if available)

Complete the following: (* indicates required field(s))

*Patient (full) Name: _____ SS #: _____

*Address (street): _____

*Address (city/state/zip): _____ *Phone #: _____

*Employer: _____

*Charity Care Requested by: _____ *Number in household: _____

Table with 2 columns: *Name, *Relationship. Includes blank lines for entry.

If you are seeking charity care for services already rendered by Brooks Memorial Hospital, list the date(s) of service:

If you are seeking an eligibility determination for services not yet rendered, check the type of service sought:

- Emergency Room In-patient Other

List the expected date(s) of Service: _____

I certify that the above information is true and accurate to the best of my knowledge. Further, I will make application for any assistance (Medicaid, Medicare, Insurance, etc.) which may be available for payment of my hospital charge, and I will take any action reasonably necessary to obtain such assistance and will assign or pay to the hospital the amount recovered for hospital charges.

Date of Request: _____ Applicant's Signature: _____

DO NOT COMPLETE - FOR HOSPITAL PERSONNEL USE ONLY

This document was received on _____ by _____

The following documents were proved to verify income and family composition.

- RETURN ORIGINALS TO PATIENT. Paycheck stubs Income Tax Form Other