



Safe harbor for your health.

riverhospital.org

4 Fuller Street • Alexandria Bay • New York • 13607

315-482-1230 Phone

315-482-5553 Fax

Charity Care Application

It is the policy of River Hospital to provide financial assistance to patients in need. You may be eligible for Financial Assistance. River Hospital offers Financial Assistance to individuals and families having difficulty with the costs of their medical care. Please complete the application below for consideration in our River Care Program.

If you have previously submitted a charity care application in the past 30 days and would like to know the status, please call the Financial Counselor. You do not need to submit another Charity Care Application.

Please indicate if you have received Charity Care in the past. Yes [ ] No [ ]

Important: Completing this application will help River Hospital determine if you can receive discounted services or other public programs that can help pay for your healthcare. Please submit this application to the hospital

Please complete this form and submit it to the hospital in person, by mail, or by fax to apply for River Care within 30 days following the date of discharge or receipt of outpatient care.

INSTRUCTIONS: COMPLETE THE APPLICATION IN FULL AND SIGN THE AUTHORIZATION TO VERIFY INFORMATION.						
Guarantor Name:			Family Size:			
Email Address						
Last Name	First	M.I.	Date of Birth	Social Security Number		
Street	Apt. #	City	State	Zip Code	Home Phone	
Employer	Address				Cell Phone	
City	State	Zip Code	Monthly Income			Work Phone
Account Number(s) or Date(s) of Service –						

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Income Information

Please provide one or more of the following for each employed family member and sign the statement below.

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1. A copy of most recent tax return
2. A copy of most recent W-2 and 1099 Forms
3. A copy of most recent pay stub
4. A statement from your employer if paid in cash
5. Any other verification from a third party about your income

You may receive income or support from another source for example SSA, disability, child support, alimony, unemployment or workers' compensation, veteran's pension or disability, TANF, retirement income, or other income). Please indicate the Source and amount of Income.

Income Source	Amount

House Hold Information: Please list all members currently living in your household.

Name	Age	Relationship

I certify that the information contained in this document is true to the best of my knowledge. I further understand that if it is determined that this information is willfully incorrect or inaccurate, I will not be eligible to participate in the River Care Financial Assistance Program.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_