NEW-YORK PRESBYTERIAN HUDSON VALLEY HOSPITAL APPLICATION FOR CHARITY CARE

Patient's Name			_ Date of Birt	:h	
Last	First	Middle Init.			
Address					
Number and Street, Apt. #		City		State	Zip
Telephone No. ()	Occupation _		Employer _		
Employer Address		Employer Tel #			
Income – List combined income for y	-	Total Last 3 Months	bers from:	Total Last 12 Months	
		Total Last 5 Months		Total Last 12 Months	8
Wages Self-employment Earnings					
Public Assistance					
Social Security					
Unemployment/Workers' Compensati	on				
Alimony					
Child Support					
Pensions Income From Dividends					
Total					
employer if applicable, Form 1040, etc. Family Size - Family members living	g in your household	d.			
Name	3 III your nousenoid		<u> </u>	Relationship	
Name		Age		Kelationship	
Note: Please attach another sheet if ac	lditional space nee	eded.			
THIS APPLICATION MAY BE SUBMITT	ED TO THE HOSPI	ITAL AT ANY TIME DURIN	G THE BILLIN	G AND COLLECTION P.	ROCESS.
ONCE YOU HAVE SUBMITTED A COM BELOW, YOU MAY DISREGARD ANY I					
TO SUBMIT THIS APPLICATION FOR C BELOW.					
I HEREBY REQUEST THAT NEWYORK ELIGIBILITY FOR CHARITY CARE. I U AND FAMILY SIZE IS SUBJECT TO VEI SUBMIT IS DETERMINED TO BE FALS! LIABLE FOR CHARGES FOR SERVICES MY KNOWLEDGE. FURTHER, I HEREFINFORMATION PERTINENT TO THIS A	-PRESBYTERIAN F INDERSTAND THA RIFICATION BY TH E, SUCH DETERMI B PROVIDED. I AFI BY GIVE MY PERM	HUDSON VALLEY HOSPITA AT THE INFORMATION WH HE HOSPITAL. I ALSO UND NATION WILL RESULT IN FIRM THAT THE INFORMA	AL MAKE A W ICH I SUBMIT DERSTAND TH A DENIAL OF TION ABOVE	RITTEN DETERMINATI CONCERNING MY AND AT IF THE INFORMATI CHARITY CARE AND T IS TRUE AND CORREC	ON OF MY NUAL INCOME ON WHICH I THAT I MAY BE T TO THE BEST O
Date Signature	of Applicant			Account #	
Completed Application to be sent to:		ork-Presbyterian Hudson Valle t Accounts Department	ey Hospital		

Patient Accounts Department 1980 Crompond Road Cortlandt Manor, NY 10567 Or FAX to: 914-734-3578