Clifton Park & Halfmoon Emergency Corps Inc.
15 Crossing Blvd. • Clifton Park, NY 12065 • (518) 371-3880 • www.cphmems.org

Charity Care Payment Application

The Clifton Park & Halfmoon Emergency Corps Charity Care Payment Program helps patients and families who are unable to pay all of their medical bills related to services.

You may qualify for a discount through the Charity Care Payment Program if:

- You do not have health insurance
- You are not eligible for Medicaid or some other type of insurance
- You meet the financial hardship criteria

If you have any questions about completing this form, please call (518) 371-3880

Patient Name: _____ **Date of Birth:** _____

Social Sec. #: _____ - _____ - _____ **Date of Service:** _____

Patient's Name/Address: _____

_____

Phone#: _____

Responsible Party's Name/Address: _____
Such as parent, guardian, or power of attorney

_____

Phone#: _____

Number of People in the household: _____

Charity Care is based on total Gross Income of the household, please list all sources of income.
(Please include copy of wage statement/pay stubs for the past 2 pay periods)

Employer and address: _____

Pre-Tax Salary: $ _____ **per week** _____

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Other Income:

❒ **Child Support**	$ _____	per month
❒ **Disability**	$ _____	per month
❒ **Alimony**	$ _____	per month
❒ **Unemployment**	$ _____	per month
❒ **Other**	$ _____	per month

❒ **Please include copy of previous year's tax return of responsible party.**

❒ If patient is claimed as a dependent on someone's tax return, include that tax information also.

INSURANCE STATEMENT: (Please check all that apply. Attach copies of all notices)

1) ❒ Have / ❒ Have Not applied for Medicaid to cover these services. If not, please explain reason:
_____

2) ❒ Have / ❒ Have Not been rejected by Medicaid. Reason for rejection:
_____

3) ❒ Have / ❒ Have Not applied insurance through the Health Care Exchange (www.healthcare.gov)
_____

General Comments and Additional Considerations:

_____
_____
_____
_____
_____

I understand that the information that I provide to Clifton Park & Halfmoon Emergency Corps is confidential and will be used to determine my eligibility for uncompensated services under the Charity Care Payment guidelines established.

Completed By: _____ Relationship: _____

Signature of patient or responsible party: _____Date: _____

Please do not forget to include all supporting documentation

Please return completed form to: Clifton Park & Halfmoon Emergency Corps Inc.
15 Crossing Blvd.
Clifton Park, NY 12065