ENH
Committed to Caring

REPEAT CHARITY CARE APPLICATION

PATIENTS NAME:_____

ADDRESS:_____

GUARANTOR'S NAME:_____

TOTAL HOUSEHOLD
INCOME:_____$_____$_____$_____
WEEKLY MONTHLY YEARLY

**ATTACH PROOF OF INCOME

HAVE YOU REAPPLIED FOR MEDICAID SINCE YOUR LAST APPLICATON? Y/N

HAS YOUR INCOME/EMPLOYMENT CHANGED SINCE YOUR LAST APPLICATION?_____

HAS YOUR MARTIAL OR DEPENDENT STATUS CHANGED SINCE YOUR LAST APPLICATION?_____

HOUSEHOLD MEMBERS

NAME	BIRTHDATE	S.S#	RELATIONSHIP

Do you or any family members listed above have any other open accounts with Eastern Niagara Hospital? Yes____ No____
If yes, please provide us with the account numbers and/or dates of service:

Patient's Name	Account #	Date of Service	Amount

Please return or mail this completed application along with proof of income to:

Eastern Niagara Hospital
Credit & Collections Coordinator
521 East Avenue
Lockport NY 14094

If you have any questions or concerns you can reach the Credit & Collections Coordinator at 514-5522.

APPLICANTS SIGNATURE:_____ DATE:_____

CERTIFICATION: In signing this application, I swear and affirm that the information I have given or will give to Eastern Niagara Hospital as a basis for Charity Care is correct.