

EASTERN NIAGARA HOSPITAL
2600 WILLIAM STREET **521 EAST AVENUE**
NEWFANE, NEW YORK 14108 **LOCKPORT, NEW YORK 14094**

REPEAT CHARITY CARE APPLICATION

Patient Name: _____

Address: _____

Guarantor Name: _____

Total household Income*:

\$ _____ WEEKLY \$ _____ MONTHLY \$ _____ YEARLY

*Attach proof of income

Have you reapplied for Medicaid since your last application? Yes ___ No ___

Has your income/employment changed since you last application? Yes ___ No ___ If yes, please explain _____

Has your marital or dependent status changed since your last application? Yes ___ No ___ If yes, explain _____

Household Members

Name	Date of Birth	Soc Sec #	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 and Medicaid denial** to :

Eastern Niagara Hospital
521 East Avenue
Lockport NY 14094
Attn: Financial Assistance Program

If you have any questions or concerns you can reach the Credit and Collections Coordinator at (716) 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.