



# River Hospital *Serving the Thousand Islands Region*

4 Fuller Street • Alexandria Bay • New York • 13607

315-482-2511 telephone

315-482-4981 facsimile

Thank you for your interest in the River Hospital financial aid program on \_\_\_\_\_ .  
Date

River Hospital is dedicated to providing quality care to our patients with financial assistance to those who may need help paying for their healthcare. Financial aid is available to patients with no insurance or whose health care benefits have been exhausted. River Hospital does not provide additional assistance with co-pays and deductibles after insurance payments. This packet provides you with the tools you need to apply for financial assistance with your hospital bill(s). Patients are expected, however, to contribute to their healthcare costs based on their ability to pay so, please complete the application in its entirety and submit all requested documentation to avoid delays or denial of assistance.

This application must be returned to River Hospital within 20 days. The application cannot be processed without the following documentation:

- Completed application
- Copies of your most recent 2 pay stubs
- Copy of last year tax return
- Copy of Medicaid denial within the past 3 months

River Hospital will not pursue further collection action while this application is in process providing you return the application timely with the required documentation. If you need additional time you must contact River Hospital at 482-1230. Please provide an explanation below for any documentation you are unable to provide:

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River Hospital will process this application within 30 days of receipt. You will be notified in writing of our decision and any remaining balance on your accounts. An installment agreement will be sent with your notification if you have any remaining balances due to River Hospital. This is an interest free agreement that will need to be signed and returned.

You have the right to appeal the Hospital's determination of financial aid if you disagree with the decision or feel you have additional hardships that should be considered. A Notice of Right to Appeal will also be included with your notification of the Hospital's decision.

**If you have any questions regarding this application, please call Cherie at 482-1230 weekdays between 8:00 AM and 4:00 PM.**

APPLICATION FOR FINANCIAL ASSISTANCE  
River Hospital, Inc

Please answer all questions completely  
(Please Print or Type)

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

Social Security Number: \_\_\_\_\_

Patient(s) Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

**Responsible Party:**

Guarantor Name: \_\_\_\_\_

SSN: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_

\_\_\_\_\_

Relationship to Patient(s): \_\_\_\_\_

Number of Dependents: \_\_\_\_\_

Employer: \_\_\_\_\_ Years there: \_\_\_\_\_ Position: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_

Present Gross Salary: \$ \_\_\_\_\_ Per: Weekly / Bi-Weekly / Monthly (circle one)

If you are unemployed do you expect to return to work? If so, when? \_\_\_\_\_

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**Spouses Employer:**

Employer Name: \_\_\_\_\_ Years there: \_\_\_\_\_ Position: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_

Present Gross Salary: \$ \_\_\_\_\_ Per: Weekly / Bi-Weekly / Monthly (circle one)

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**Other Income:**

(circle one if applies) Social Security    V.A.    Welfare    Other: \_\_\_\_\_

Any other income: \$ \_\_\_\_\_ Per: Weekly / Bi-Weekly / Monthly (circle one)

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**ASSETS:**

Do you own or rent your home? \_\_\_\_\_ Monthly payment: \_\_\_\_\_

Name of Landlord/mortgage holder: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

Approximate market value (if you own)? \_\_\_\_\_ Are payments current? \_\_\_\_\_

Other Real Estate owned? \_\_\_\_\_ Market value? \_\_\_\_\_ Equity: \_\_\_\_\_

Location: \_\_\_\_\_

Automobile(s)

Make \_\_\_\_\_ Year \_\_\_\_\_ Current Value \$ \_\_\_\_\_ Balance Owed: \_\_\_\_\_

Make \_\_\_\_\_ Year \_\_\_\_\_ Current Value \$ \_\_\_\_\_ Balance Owed: \_\_\_\_\_

Do you own a boat? \_\_\_\_\_ Camper? \_\_\_\_\_ Equity: \_\_\_\_\_



**Applicable Resources:**

Checking Account Number(s)

\_\_\_\_\_ Institution/Branch: \_\_\_\_\_ Balance: \_\_\_\_\_

\_\_\_\_\_ Institution/Branch: \_\_\_\_\_ Balance: \_\_\_\_\_

Savings Account Number(s)

\_\_\_\_\_ Institution/Branch: \_\_\_\_\_ Balance: \_\_\_\_\_

\_\_\_\_\_ Institution/Branch: \_\_\_\_\_ Balance: \_\_\_\_\_

Cash on hand: \$ \_\_\_\_\_ Certificates of Deposit: \$ \_\_\_\_\_

Savings Bonds: \$ \_\_\_\_\_ Stocks and/or Bonds: \$ \_\_\_\_\_

Accumulated dividends on Life Insurance Policies: \$ \_\_\_\_\_

Money Markey Accounts: \$ \_\_\_\_\_



**Monthly Household Expenses:**

Mortgage/Rent     \$ \_\_\_\_\_  
 Electric            \$ \_\_\_\_\_  
 Heat                 \$ \_\_\_\_\_  
 Cable/Satellite    \$ \_\_\_\_\_  
 Water/Sewer        \$ \_\_\_\_\_  
 Telephone          \$ \_\_\_\_\_  
 Cell phone          \$ \_\_\_\_\_

**Yearly Household Expenses:**

School/Land Taxes \$ \_\_\_\_\_  
 House Insurance    \$ \_\_\_\_\_  
 Vehicle Insurance   \$ \_\_\_\_\_  
 Health Insurance    \$ \_\_\_\_\_  
 Life Insurance        \$ \_\_\_\_\_



**OTHER DEBTS:**

| Type:         | Owed To: | Present Balance | Will be paid off by: | Monthly Payment |
|---------------|----------|-----------------|----------------------|-----------------|
| Bank Notes    | 1.       |                 |                      |                 |
|               | 2.       |                 |                      |                 |
| Personal Loan | 1.       |                 |                      |                 |
|               | 2.       |                 |                      |                 |
|               | 3.       |                 |                      |                 |
| Credit Cards  | 1.       |                 |                      |                 |
|               | 2.       |                 |                      |                 |
|               | 3.       |                 |                      |                 |
|               | 4.       |                 |                      |                 |
|               | 5.       |                 |                      |                 |
| Medical Bills | 1.       |                 |                      |                 |
|               | 2.       |                 |                      |                 |
|               | 3.       |                 |                      |                 |
|               | 4.       |                 |                      |                 |
|               | 5.       |                 |                      |                 |



**References:**

Please indicate any references we may contact to verify your hardship.

1. \_\_\_\_\_ Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

2. \_\_\_\_\_ Address: \_\_\_\_\_ Phone #: \_\_\_\_\_



**In signing this application, I swear and affirm that the information I have given or have been requested to give River Hospital, Inc. as a basis for reduced payments or Charity Care is true and correct.**

\_\_\_\_\_  
(Guarantor's Signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Spouse's Signature)

\_\_\_\_\_  
(Date)



Requested/Sent: \_\_\_\_\_

Received: \_\_\_\_\_