Financial Assistance Application

ALBANY MED Health System

Applicant/Patient Name

(First, Middle, Last)

The Albany Med Health System understands that receiving medical care sometimes includes unexpected expenses and that you may need assistance. The Albany Med Health System Financial Assistance Program can help you.

The first step in seeking this support is to complete this Financial Assistance Application and provide the applicable documents listed below. All information will remain confidential and will help guide our processes. Check those documents below that you have included.

- ☐ Your completed financial assistance application
- ☐ Complete copy of most recent year's federal income tax return(s) for household members
- ☐ Check here if you were not required to file a tax return
- ☐ If currently employed, copies of last 4 consecutive payroll stubs for patient, guarantor (if different from patient) and spouse/domestic partner
- ☐ Last two consecutive banking statements (checking/savings), investment statements and other assets
- ☐ If self-employed, copies of your federal tax form Schedule C
- ☐ If retired and receiving Social Security, a copy of your SSA 1099 form
- ☐ Social Security disability statements
- ☐ Workers' Compensation statements
- ☐ Unemployment statements
- ☐ Veterans benefits
- ☐ Pension statement
- ☐ Public assistance
- ☐ Medicaid determination letter

Please check the location where the patient received care and forward the application to the address indicated to the right. If you received services from multiple care providers, please submit only one application to the hospital where you received care.

- ☐ Albany Medical Center Hospital
- ☐ Albany Medical College (including EmUrgent Care Facilities)

Albany Medical Center
Patient Financial Services
Attn: Financial Aid Specialist
1275 Broadway
Albany, NY 12204

- ☐ Columbia Memorial Hospital
- ☐ Columbia Memorial Regional Medical, PLLC

Columbia Memorial Health
Patient Financial Services
PO Box 2000
Hudson, NY 12534

- ☐ Glens Falls Hospital
- ☐ Glens Falls Medical, PLLC

Glens Falls Hospital
Patient Financial Services
Attn: Financial Assistance
100 Park Street
Glens Falls, NY 12801

- ☐ Healthcare Partners of Saratoga, Ltd (Malta Med Emergent Care)
- ☐ Saratoga Hospital
- ☐ Saratoga Regional Medical, P.C.

Saratoga Hospital
Patient Financial Services
PO Box 5178
Saratoga Springs, NY 12866

Financial Assistance Application

ALBANY MED Health System

Patient Name (complete information that is applicable)

(First, Middle, Last)		
Date of Birth (mm/dd/yyyy)	Social Security Number	
Address		
City	State	Zip
Contact Phone #	Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced	

Responsible Party (complete this section if responsible party is not the patient)

(First, Middle, Last)		
Date of Birth (mm/dd/yyyy)	Social Security Number	
Address		
City	State	Zip
Contact Phone #	Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced	

Spouse/Domestic Partner and Dependents (list all members of the household)

Full Name	Relationship	Date of Birth	Income
1.			
2.			
3.			
4.			
5.			
6.			

I understand that the information I submit is subject to verification by the Albany Med Health System. I certify that the information is true and correct to the best of my knowledge. My signature indicates that I am aware that verification will be done by means including credit bureau inquiries and employment verification.

Patient/Responsible Party

Print Name	Date
Signature	

For Office Use Only:

% Approved	Approval Period