

Name: _____

Address: _____

City/State/Zip: _____

Phone Number: _____

Soc. Sec. No.: _____

Date of Birth: _____

Employer: _____

Employer Address: _____

Employer Phone: _____

Date of Hire: _____

Hrs worked per Week: _____

Med Ins Company: _____

DSS Case Worker: _____

Caseworker Phone: _____

Family Members (in household)

Birth Date

Relationship

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please describe your personal situation and your reasons for requesting assistance:

You must return copies of the following documents with this application. Any application without signature and the necessary documents will be denied.

Documentation Check Off List

- _____ Proof of Income---paycheck stub, letter from employer
- _____ Previous Year Federal Income Tax Return
- _____ Last statement for checking, savings, stocks, bonds, annuities, etc.

I have read and understand the above conditions to receive financial assistance. I also understand that all the information on this application will be verified by the staff at Catskill Regional Medical Center and this will serve as a release for income verification. I swear all statements in this application are true and correct. If any information submitted is found to be false it shall be cause for denial of this application and revocation of any previous financial assistance.

Signature of Applicant

Date