Catholic Health Services of Long Island

As a ministry of the Catholic Church, CHS continues Christ's healing mission, promotes excellence in care, and commits itself to those in need. CHS affirms the sanctity of life, advocates for the poor and underserved, and serves the common good. It conducts its healthcare practice, business, education and innovation with justice, integrity and respect for the dignity of each person.

☐ GOOD SAMARITAN HOSPITAL ☐ MERCY MEDICAL CENTER ☐ ST.CATHERINE OF SIENA

☐ ST. CHARLES HOSPITAL ☐ ST. FRANCIS HOSPITAL ☐ ST. JOSEPH HOSPITAL

Applicant/Guarantor Information:

Applicant/Guarantor Name: _____ Guarantor Social Security # _____-_____-_____

Address: _____ City**:** _____ State: _____ Zip Code: _____

Home Phone #: (_____)_____-_____ Cell Phone #: (_____)_____-_____ Work Phone #:(_____)_____-_____

Patient Information:

Patient Name**:** _____ Patient Social Security # _____-_____-_____

Date of Birth: _____/_____/_____ Account #'s**:** _____

Patient's Relationship to Applicant/Guarantor:

☐ Self ☐ Spouse ☐ Parent/Legal Guardian ☐ Child ☐ Other: _____

Do you have health insurance? ☐ **Yes** ☐ **No** **If yes, please specify:**_____

Total Family Size: **List the dependents who reside in the applicant's house for whom the applicant takes financial responsibility.**

Family Size - Number in Household: _____

Check the appropriate box for each dependent

NAME	**AGE**	**RELATIONSHIP**			
		Spouse/Partner	Parent	Child	Other
1.		☐	☐	☐	☐
2.		☐	☐	☐	☐
3.		☐	☐	☐	☐
4.		☐	☐	☐	☐
5.		☐	☐	☐	☐
6.		☐	☐	☐	☐

Total Gross Monthly Income for the last 30 days:

Source of Income	Applicant/Patient	Spouse/ Live In Partner
Wages	**$**	**$**
Social Security Payment	**$**	**$**
Unemployment Compensation	**$**	**$**
Disability Payment	**$**	**$**
Workers Compensation	**$**	**$**
Alimony / Maintenance	**$**	**$**
Dividends, Interests, Rental Income	**$**	**$**
Other Income	**$**	**$**
Total Income	**$**	**$**

Assets

- Do you rent or own home (primary residence) ☐ **Rent** ☐ **Own**
- Do you own a secondary home ☐ **Yes** ☐ **No**

Bank Accounts

- Checking Account Balance(s) $ _____
- Savings Account Balances(s) $ _____

Monthly Household Expenses **$**_____

Outstanding Medical Expenses (please list) **$**_____

Certification by Applicant

I certify to the best of my knowledge that the information and documentation provided is truthful, complete and accurate. I understand that the information which I submit is subject to verification by the appropriate facility and any willful misrepresentation of these facts will make me liable for all Hospital charges. I will apply for governmental or private medical assistance for payment of my medical expenses. I understand that it is my responsibility to promptly advise the Hospital of any changes to my income or assets.

X _____ _____ / _____ / _____

Applicant Signature/Patient Signature (Parent/Legal Guardian-Minor Child) **Date**

Please return completed applications with supporting documentation to the providing facility or mail completed applications to:

CHS HOSPITAL - Financial Assistance Department
Address Line 1
City, State xxxxx