

Catholic Health is proud to carry out its mission of providing quality care across our system. If payment for services listed below created a financial hardship for you, you may be eligible for our financial assistance program. To apply, please print this letter and provide the required information below:

| Patient | Full Name: | |
|---------------------|---|--|
| Patient <i>i</i> | Address: | |
| Patient | Date of Birth: | Contact Phone: |
| Bill/Gua | rantor Number: | |
| 1. | Provide the number of people in your household_ | |
| 2. | | ent pay stubs for all people in the household; Copies of the last cople in the household; self-employment business records of statement verifying no income sources. |
| 3. | Please mail required information along with this o | completed letter in the enclosed envelope or fax to 716-961-4458. |
| By signi | ng below you are requesting consideration for finar | ncial assistance. |
| Signatuı | re: | Date: |
| applicat | | t this application along with all required documents. While your eive from Catholic Health. If you have already paid this balance in |
| Please c informa | | ww.chsbuffalo.org/billing-insurance/financial-assistance for more |
| Mail req | quired information along with this completed letter w | vithin 30 days to: |
| 144 Gen Buffalo, | Health/RMC nesee Street 3 rd Floor NY 14203 redit & Collections | |
| Thank y | ou for choosing Catholic Health for your healthcare n | needs. |
| Patient l | Financial Services | |
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