Dear Patient:

Thank you for choosing Catholic Health for your healthcare needs! We are pleased to offer you this opportunity to apply for financial assistance. To be considered for our Healthcare Assistance Program, please print this letter and provide the information required below:

Patient Full Name: _____
Patient Date of Birth: _____
Contact Phone: _____
Patient Address: _____
_____

Account Number from Bill: _____

Number of People in Household (you, your spouse, and number of children under 18):_____

Additionally, please include:

- A brief letter of hardship stating you would like to apply for healthcare assistance
- Proof of your household income* *(*Acceptable proof of income is a signed copy of your most recent federal tax return, or last three unemployment payment benefit statements, or last two Social Security statements, or your last three pay stubs from your employer, or a signed and notarized statement verifying no income sources)*

This letter and requested documentation must be received before the account is placed with an outside collection agency. Any additional questions can be directed to our Customer Service Team at (716) 601-3600.

Please mail the information along with this completed letter to:

Catholic Health/RMC
144 Genesee Street, 3rd Floor
Buffalo, NY 14203
Attn: Supervisor, Credit & Collection Department

Thank you,

Patient Financial Services