Catholic Health

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.

Please complete this section below IN FULL for each patient in your household who is in need of financial assistance. If additional space is needed, please utilize the back of this form.

Patients Full Name(s): ______________________________

Patient Address: ______________________________

______________________________Phone:______________________________

Date of Birth:__________________ Race:______________ Gender:___________ Ethnicity: ______________

Insured (Yes or No)___________ Name of Insurance:______________________________

Patients Full Name(s): ______________________________

Patient Address: ______________________________

______________________________Phone:______________________________

Date of Birth:__________________ Race:______________ Gender:___________ Ethnicity: ______________

Insured (Yes or No)___________ Name of Insurance:______________________________

Patients Full Name(s): ______________________________

Patient Address: ______________________________

______________________________Phone:______________________________

Date of Birth:__________________ Race:______________ Gender:___________ Ethnicity: ______________

Insured (Yes or No)___________ Name of Insurance:______________________________

Patients Full Name(s): ______________________________

Patient Address: ______________________________

______________________________Phone:______________________________

Date of Birth:__________________ Race:______________ Gender:___________ Ethnicity: ______________

Insured (Yes or No)___________ Name of Insurance:______________________________

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Bill/Guarantor Number(s): _____

1. **Provide the number of people in your household_____.**

2. **Copies of the last three pay stubs or unemployment pay stubs for all people in the household; Copies of the last two Social Security Payment Statements, pension statements, other income for all people in the household; self-employment business records of earnings and expenses; or a signed and notarized statement verifying no income sources.**

3. **You may mail, fax (716-961-4458) or upload to MyChart. A signed copy of this letter must be included as well as the required financial information.**

By signing below you are requesting consideration for financial assistance.

Signature: _____ Date: _____

You have 240 days from your first billing statement to submit this application along with all required documents. While your application is being reviewed you may disregard bills you receive from Catholic Health. If you have already paid this balance in full, you may still apply for financial assistance.

Please call us at 716-601-3600 or visit our website https://www.chsbuffalo.org/billing-insurance/financial-assistance for more information.

Mail required information along with this completed letter within 30 days to:

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

Thank you for choosing Catholic Health for your healthcare needs.

Patient Financial Services