



NORTH COUNTRY
ORTHOPAEDIC GROUP™

Date: _____

Dear North Country Orthopaedic Group, P.C. Patient:

I have enclosed an application for financial assistance at North Country Orthopaedic Group, P.C.. Financial assistance, in the form of a sliding scale charity discount, is available to residents of New York State only. Consideration for financial assistance will apply to eligible services that are considered essential health services provided and billed under North Country Orthopaedic Group, P.C. Please be advised the financial assistance does not cover convenience items, such as elective cosmetic services, services provided by a private or interpreting physician group. We have also included for your convenience, a telephone number to help assist you to see if you are eligible for low cost or no cost insurance. Please review and complete all questions, as the determination for eligibility is based on the information provided. We will need copies of the following where applicable:

1. Copies of last four (4) consecutive weeks of pay stubs (two (2) if paid bi-weekly).
2. Copies of four (4) of your most recent unemployment stubs, if not working.
3. For self-employed persons, a three (3) month business ledger or self- attestation form (a tax return is helpful, but optional).
4. Copy of Social Security/Disability income statement. If direct deposit, please provide a copy of your bank statement.
5. Where no type of income documentation is available, the self-attestation form may be used.
6. The most current two (2) months bank statement or deposit statement.

If you have a financial or personal situation you would like taken into consideration, please include a letter with your application.

Please return your completed application to the Credit Counselor office at the address located on the bottom of the application within thirty (30) days.

**** Once a completed financial assistance program application has been received by North Country Orthopaedic Group, P.C. you may disregard any billing statements until a determination of eligibility has been made.**

If you have any questions, please contact the Credit Counselor at (315) 836-2113.

Sincerely,

Credit Counselor

North Country Orthopaedic Group, P.C. Financial Assistance Program Application

Please Print

Patient's Name _____
 First Last MI Date of Birth
Address _____
 Street City State Zip Code
Phone _____ Number of dependents in household _____

Household Information

(Please include everyone residing in the household including the applying patient)

Name	Date of Birth	Relationship to Patient
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Income

(Please enter income under the appropriate source and enter monthly or dollar amount.)

	Patient	Spouse	Parents (if patient is a child)	Monthly Income	Annual Income
Wages				\$	\$
Social Security				\$	\$
Pension				\$	\$
Disability				\$	\$
Unemployment				\$	\$
Workers Comp				\$	\$
VA Benefits				\$	\$
Child Support				\$	\$
Alimony				\$	\$
Rental Income				\$	\$
Interest Dividends				\$	\$
Other Income				\$	\$

I certify that the above information is true and accurate to the best of my knowledge.

Signature _____ Date _____

Upon submitting a completed application, you may disregard any bills until you receive notification of a determination of your application. The applicant will have ninety (90) days from the date of the first statement to request an application and thirty (30) days to submit the completed application. A decision regarding the application will be made within thirty (30) working days. Applicants will be notified by letter of the decision. Applicants may request a review of denial or partial denial within thirty (30) days from the denial notice. Applicants wishing to appeal the denial may do so by requesting so in writing with additional documentation or any financial or personal situation that they would like taken into consideration.



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SELF ATTESTATION OF INCOME

This form should be used by patients who have no other type of documentation to verify their income.

Please Print

Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

- I get paid in cash and do not receive a pay stub

- I am self-employed

Please indicate your gross monthly income: \$ _____

I certify that I have no other way to document the above income. I affirm that the income information provided is true, complete and correct to the best of my ability.

Signature: _____ Date: _____