HEMATOLOGY/ONCOLOGY ASSOCIATES
OF CENTRAL NEW YORK

Thank you for contacting Patient Financial Services. Our goal is to help you get the assistance for your financial medical needs with our practice. Our patient advocates are here to assist and work with you during this process.

Please fill out the attached application for financial assistance and return to one of our patient advocates.

You must include 2 recent months of expense statements & proof of income with your application for all household members.
Acceptable forms of income are:

- 2 current pay stubs for all employment
- Most recent W-2's
- 2 pages of most recent Federal 1040 Tax Form
- Social Security Benefit Statement

We will review and process your application once all completed documentation is received. Once the review is complete we will contact you with your payment agreement options. All patients will be encouraged to enroll their auto-payment on the patient portal.

If you need assistance or have questions regarding this application process please feel free to reach out to one of our patient advocates.

(315) 472-7504 Dara X-1076 or Brooke X-1077

Financial Assistance Application

Name of Patient_____ Date of Birth_____
Address_____ SSN_____
_____ Marital Status_____
Home Phone _____Cell Phone_____
Patient Employer_____Work Phone _____
Employer Address_____

Name of Spouse_____ Date of Birth_____
Address_____ SSN_____
_____
Home Phone _____Cell Phone_____
Spouse Employer_____Work Phone _____
Employer Address_____

Number of Family / Household Members_____
Gross Family Income $_____

Please attach 2 months of recent statements for each expense listed below

Expense Description	Company/Name	Monthly Average
Mortgage/Rent		$
Utilities		$
Auto		$
Groceries		$
Medical Expenses		$
Other		$

Certification

I certify that all information listed is true and correct to the best of my knowledge. I understand that the information is to be used to ascertain my ability to pay for services provided by Hematology/Oncology Assoc. of CNY. I give Hematology/Oncology Assoc. of CNY permission to release this information only when necessary in financial operations. I will provide any additional information if requested to do so to prove accuracy of the information stated above.

Patient Signature_____Date_____
Spouse Signature_____Date_____