Town of Montgomery
Emergency Medical Services

PO Box 25
Walden, NY 12586

Charity Care Application

Patient Name: _____Patient Number: _____

Marital Status: _____ Patient SS#: _____Date of Birth: _____ Patient Phone #: _____

Home Adress: _____

Mortgage: _____ Rent: _____ Employer: _____Email: _____

Gross Monthly Income

Source	**Patient Income**	**Spouse- Significant Other-Partner Income**	**Total Monthly Income**
Wages/ Salary			
Self-Employment			
Social Security/ Disability			
Retirement Pension			
Workers Compensation			
Unemployment			
Child Support/ Alimony			
Other:			

List Members of your household

Name	**Date of Birth**	**Relationship to Patient**

Important:

1. Application must be complete and signed. All supporting documents must be turned in with application.
2. Return the completed application within 30 days of first billing statement.
3. Your request will be reviewed and you be notified in writing of our determination within 30 days.

Documentation Check List

1. Photo ID. (Driver's License, Passport, or Sheriff's Photo, etc.)
2. Proof of income (four most recent paystubs, unemployment statement, and/or Social Security statement)
3. Two most recent bank statements
4. Most recent tax return (must be signed)

Disclaimer

I have read and understand the above conditions. I also understand that all of the information on this application will be verified by the staff at Town of Montgomery EMS billing department. This document will serve as a release of income verification. I swear all statements in this application are true and correct. Submitting false information will be cause for eligibility denial.

_____ _____

Signature of Applicant **Date**