The Healthcare Consortium

Financial Assistance Application

Applicant Information

Full Name _____ Date _____
Last *First* *M.I.*

Address _____

Are you a full time resident? YES ☐ NO ☐ *If no, please explain:* _____

Phone _____ Email _____

Date of Birth _____ Age _____

Name of person completing form (if different from applicant) _____

What is the relationship of the person completing the form to the applicant?

Self ☐ Spouse ☐ Child ☐ Other ☐ _____

Is the applicant currently undergoing active cancer treatments? YES ☐ NO ☐

Please submit a note from a physician confirming this with your application

What are the types of expenses for which financial assistance would be used?

- ☐ Health insurance premiums
- ☐ Medical bills (deductibles, co-payments, co-insurance
- ☐ Prescription medications
- ☐ Food
- ☐ Transportation expenses (e.g. vehicle fuels, repairs, etc)
- ☐ Rent or mortgage payments
- ☐ Utility bills
- ☐ Other: _____

Benefits Information

Do you have health insurance? YES ☐ NO ☐

If **YES**, what type? MEDICARE ☐ MEDICAID ☐ PRIVATE ☐ OTHER ☐

If **NO**, have you applied for Medicaid or other health insurance? YES ☐ NO ☐

If you have applied, what is the status of that application? _____

Have you applied for Disability? YES ☐ NO ☐

If you have applied, what is the status of that application? _____

Are you receiving SNAP benefits (food stamps), cash assistance and/or HEAP through the Department of Social Services? YES ☐ NO ☐

If **YES**, what is the amount received for:

SNAP (food stamps) $_____

Cash Assistance $_____

HEAP $_____

If **NO**, have you applied? YES ☐ NO ☐

If you have applied, what is the status of that application? _____

Income & Residency

Tell us about the applicant's living situation (please check all that apply)

OWN ☐ RENT ☐ STAY WITH FAMILY ☐ HOSPITAL/NURSING/OTHER FACILITY ☐ OTHER ☐_____ss

Total Liquid Assets $_____

(the sum of all dollars in cash, checking and savings accounts)

All Other Assets:

Retirement Accounts $_____

Properties (other than the primary residence) $_____

Stocks, bonds and investments $_____

Summary

Why are you applying for Financial Assistance at this time? Please briefly describe the financial hardship that you are experiencing.

_____

_____

_____

Amount requested from the fund: $_____

Requests may be up to $1,000 in Columbia, $750 in Greene and are subject to the lifetime maximum award

With my signature below, I attest that all information provided on this form is true and accurate.

Signature of Applicant: _____ Date: _____

Complete and return to:

Columbia County Community Healthcare Consortium, Inc.
Attn: R. Cole
325 Columbia Street Suite 200 Hudson, NY 12534

For Office Use Only

Determination of the Application Review Committee:

If assistance will be provided, what is the source?

CC Cancer Fund ☐ GC Cancer Fund ☐ Jan Koweek Fund ☐ Dyson Foundation ☐ Comp. Ther. Fund ☐

If assistance will be provided, what is the associated P/O # _____

The Healthcare Consortium

HIPAA Release Form

Instructions:
Please complete all highlighted sections of this HIPAA release form.

If any sections are left blank it will not be possible for us to process your application.

Name: _____ Date of birth: _____

I hereby request and authorize a release and free exchange of information between the Columbia County Community Healthcare Consortium and _____

Name and address of provider or pharmacy
(a separate form must be completed for each provider or pharmacy)

Please detail the reasons why information is being shared:

_____
_____
_____

Time frame that information can be released to above mentioned:

From _____ to _____

I acknowledge the rights granted to me under HIPAA allow me to revoke this authorization at any time, provided that such revocation is in written format.

_____ _____

Signature of Individual Date

_____

Signature of Columbia County Community Healthcare Consortium Staff Member