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:

Patient Full Name: _____

Patient Address: _____

_____

Patient Date of Birth: _____ Contact Phone: _____

Bill/Guarantor Number: _____

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 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. **Please mail required information along with this completed letter in the enclosed envelope or fax to 716-961-4458.**

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