



CareMount Medical

Financial Assistance Program

CareMount Medical recognizes that there are times when patient in need of care will have difficulty paying for the services provided. CareMount Medical's Financial Assistance Program provides discounts to qualifying individuals based on financial circumstance. Please contact 914-242-2719, email us at tdelgard@cmmmedical.com or visit our Patient Assistance Department at 110 South Bedford Road in Mount Kisco for an application or any questions regarding bills can be directed to our call center 914-242-1388.

We ask that you provide the following documentation:

1. Completed Application
2. A copy of your most recent Tax return
3. Proof of Social Security, Unemployment Benefit, or any other income you may receive.
4. Charity Care Approval Letter from any local hospital.

As much as we dislike requesting this information from our patients, we feel that is reasonable and appropriate to do so when being asked for special financial assistance.

All information provided will be held strictly confidential. Once we receive this information, we can then determine what assistance you may qualify for.

Applications to be mailed to CareMount Medical 90 South Bedford Rd Mount Kisco New York 10549 Attn: Theresa Rose DelGardo / Chappaqua Crossing office.



caremountmedical.com

CAREMOUNT MEDICAL FINANCIAL ASSISTANCE APPLICATION

Account # _____

Patient Name _____ Date of Birth _____

Mailing Address _____

Home phone _____ Cell phone _____

Family size/ number in household _____

Family Household Names and dates of birth

Name	Relationship	Date of Birth
1.		
2.		
3.		
4.		
5.		
6.		

Income

Type of income	Patient	Spouse
Wages	_____	_____
Social Security Payment	_____	_____
Unemployment Compensation	_____	_____

Disability	_____	_____
Workers Compensation	_____	_____
Alimony/Child Support	_____	_____
Dividends/Interest/Rentals	_____	_____
All other income	_____	_____
Total	_____	_____

If you have any questions or need assistance, please call _____, or the Patient Assistance Call Center at 914-242-1388.

Please send the signed and completed application to CareMount Medical
90 South Bedford Road
Mt. Kisco, NY 10549
Attn: Financial Assistance

I affirm that the above information is true, complete and correct to the best of my knowledge.

Applicant/ Parent/ Guardian Signature _____ Date _____