East Adams Rural Healthcare

Charity Care / Financial Assistance Application

Instructions: Complete this form to apply for free or reduced-cost care.
Submit with proof of income (pay stubs, tax return, or benefits letter).
Applications are available in English and Spanish. Interpreters are available upon request.

Patient Name: _____ Date of Birth: _____

Address: _____

Phone: _____ Email: _____

Household Size: _____ Total Monthly Income: _____

Income Sources (check all that apply): Employment [ ] Social Security [ ] Other [ ]

Health Insurance (if any): _____

Public Benefits (Medicaid, SNAP, WIC, TANF, SSI, etc.): _____

Reason for Applying (hardship, unemployment, underinsured, etc.): _____

Signature: _____ Date: _____

Your Rights:

- You cannot be denied emergency or medically necessary care based on ability to pay.
- You may request help completing this form at no cost.
- Collection actions will stop while your application is being reviewed or appealed.
- You have the right to appeal a denial of charity care.
- If approved, discounts will apply retroactively to eligible bills.