

NYU HOSPITALS CENTER FINANCIAL ASSISTANCE SUMMARY



La solicitud y el resumen de asistencia financiera también se encuentran disponibles en español.

Заявление на получение финансовой помощи и форма “Summary” также доступны на русском языке.

財務補助表格與概要也有中文版。

NYU Hospitals Center recognizes that there are times when patients in need of care will have difficulty paying for the services provided. The Hospital provides discounts to qualifying individuals based on income. In addition, we can help you apply for free or low-cost insurance if you qualify. Just contact our Financial Counseling Office at 1-866-486-9847 or go to Room Tisch SK-109-L for free, confidential assistance.

Who qualifies for a discount?

Financial assistance is available for patients with limited incomes who have no health insurance or have exhausted their health insurance benefits.

Every New York State resident who needs medically necessary services and every person who needs emergency services at Tisch Hospital, Rusk Institute or NYU Hospital for Joint Diseases can get a discount if they meet the income limits. You cannot be denied medically necessary care because you need financial assistance. You may apply for a discount regardless of immigration status.

What are the income limits?

The amount of the discount varies based on your income and the size of your family. If you have no health insurance, have exhausted your insurance benefits, or have incurred deductibles, co-pays or coinsurance, these are the income limits:

*Based on the 2016 Federal Poverty Level Guidelines

Income Based Federal Poverty Levels 2016

Family Size	100% Discount (SC1)	100% Discount (SC1)	100% Discount (SC1)	100% Discount (SC1)	75% Discount (SC2)	50% Discount (SC3)	25% Discount (SC4)
	(Weekly) 150% FPL	300% FPL	400% FPL	600% FPL	650% FPL	700% FPL	800% FPL
1	\$343	\$685	\$914	\$1,371	\$1,485	\$1,599	\$1,828
2	\$462	\$924	\$1,232	\$1,848	\$2,003	\$2,157	\$2,465
3	\$582	\$1,163	\$1,551	\$2,326	\$2,520	\$2,714	\$3,102
4	\$701	\$1,402	\$1,869	\$2,804	\$3,038	\$3,271	\$3,738
5	\$820	\$1,641	\$2,188	\$3,282	\$3,555	\$3,828	\$4,375
6	\$940	\$1,880	\$2,506	\$3,759	\$4,073	\$4,386	\$5,012
7	\$1,060	\$2,119	\$2,825	\$4,238	\$4,591	\$4,944	\$5,651
8	\$1,180	\$2,359	\$3,145	\$4,716	\$5,111	\$5,504	\$6,291
Additional Person add	\$117	\$234	\$312	\$468	\$508	\$547	\$625

What if I do not meet the income limits?

If you cannot pay your bill, the Hospital can offer a payment plan. The amount you will pay depends on your income but in any event will not exceed 10% of your gross monthly income.

Can someone explain the discount? Can someone help me apply?

Yes, free, confidential help is available. Call the Financial Counseling Office at 1-866-486-9847. If you do not speak English, someone will help you in your own language.

The Financial Counselor can tell you if you qualify for free or low-cost insurance, such as Medicaid, Child Health Plus and Family Health Plus. If the Finance Counselor finds that you don't qualify for low-cost insurance, they will help you apply for a discount. The Counselor will help you fill out all the forms and tell you what documents you need to bring.

What do I need to apply for a discount?

The Financial Counselor will provide you with an application. Just complete the application and submit it to the Financial Counseling Services Unit.

What services are covered?

This Policy does not cover: cosmetic procedures; services provided by physicians and other health care providers who treat you at NYU Hospitals Center but are not employed by the hospital and bill separately from the Hospital, such as physicians employed by NYU School of Medicine in their private practice, anesthesiologists, radiologists, private duty nurses, ambulette service providers, home care service providers; elective procedures for patients who are enrolled in HMO/commercial insurance plans which do not contract with the Hospital; and discretionary charges such as telephones, televisions and private room differential charges.

How much do I have to pay?

Discounts are determined based on the income test described above. You can pay as little as \$0 if your income is 600% or less of the Federal Poverty Level and meet all the other qualifications for eligibility.

Our Financial Counselor will give you the details about your specific discount(s) once your application is processed.

How do I get the discount?

You have to fill out the application form. As soon as we have the information on your residency, income, and family size we can process your application for a discount.

You can apply for a discount before you have an appointment, when you come to the hospital to get care, or when the bill comes in the mail. Send the completed form to NYU Hospitals Center, c/o Financial Counseling Services at 550 First Avenue, Room SK-109-L, NY, NY 10016.

Patients will have at least ninety (90) days from the date of service or discharge to apply for financial assistance. Patients will have a least another twenty days from receipt of the application materials from the hospital to provide the information.

How will I know if I was approved for the discount?

The Hospital will send you a letter within 30 days after completion and submission of the application, telling you if you have been approved and the level of discount you qualify for.

What if I receive a bill while I'm waiting to hear if I can get a discount?

You are not required to pay a hospital bill while your application for a discount is being considered. If your application is turned down, the Hospital must tell you why in writing and must provide you a means to appeal the decision to a higher level within the Hospital.

What if I have a problem I cannot resolve with the Hospital?

You may call the New York State Department of Health complaint hotline at 1-800-804-5447.

<p>For Administrative use only Facility _____ Account # _____ Med Rec# _____</p>	<p>Financial Assistance Application (Attachment A)</p>	<p>For Administrative use only Patient Type _____ Amount of W/O \$ _____ Method of Calculation _____</p>
--	--	--

I. Patient Demographics

Patient Name: _____
(Last) (First) (Middle) (SSN – NOT REQUIRED) (DOB)

Guarantor Name: _____
(Last) (First) (Middle) (SSN – NOT REQUIRED) (DOB)

Address: _____
(Street) (City) (State) (Zip code)

Home Telephone: _____ Work Telephone: _____ Cell Telephone: _____

II. Household Information

Patient Marital Status:	Married	Single	Separated	Total Number in Household:
<small>(Circle One)</small>				
Spouse & Dependent Name(s): <small>(Attach separate sheet for additional dependents)</small>	Date of Birth	Social Security Number (NOT REQUIRED)		

III. Current Employment Information

Employee Name (Patient, Guarantor, Spouse, or Dependent):	Employer Name, Address and Dates of Employment
	<i>Hire Date:</i>
	<i>Hire Date:</i>
	<i>Hire Date:</i>

IV. Insurance Information (Attach separate sheets for additional Insurance information)

Are you covered by or are you applying for any health insurance (Including Medicaid, Child Health Plus, Family Health Plus, or Healthy NY)?	YES	NO
If yes, please explain: <small>(include insurance company name, address, telephone number, policy/group number and subscriber information)</small>		

V. **Other Information**

Is treatment the result of an accident or injury?	YES	NO
If Yes, date of accident:		
Brief description of the accident:		

Street, City and State of accident:
Will a homeowner's or liability insurance be involved?

Financial Assistance Application
(Attachment B)

VI. Financial Statement

Enter totals for Patient, Guarantor, Spouse and Dependents: (Add additional sheets as necessary)

MONTHLY INCOME:	AMOUNT:
Gross Wages, Salaries, Tips	\$
Social Security	\$
Disability	\$
Unemployment	\$
Child Support	\$
Alimony/Maintenance	\$
Rental Income	\$
Property Income	\$
Pension	\$
Dividends/Interest	\$
Other Income (Specify):	
	\$
	\$
	\$

CERTIFICATION

I certify that the above information is true and accurate to the best of my knowledge. I understand that fraudulent or misleading information will make me ineligible for any financial assistance. I authorize the release of any information needed to verify the information provided and for billing and collections in compliance with applicable federal and state laws. Further, I will make application for any assistance (Medicaid, Medicare, Insurance, etc.) which may be available for payment of my hospital charges, and I will take any action reasonably necessary to obtain such assistance and will assign or pay to the hospital the amount recovered for hospital charges.

I understand that this application is made so that the hospital can determine my eligibility for Financial Assistance based on the established criteria on file in the hospital.

In addition, I agree to provide additional information as requested in order to determine eligibility. I agree to inform NYU Hospitals of any change in my needs, insurance eligibility, income, property, living arrangements or address as they occur.

Signature of Applicant: _____ Date _____

Signature of Interviewer: _____ Date _____

New York State offers various low cost health insurance plans that are available for children, individuals, families and small businesses. Contact Information:



1-800-698-4543



1-877-934-7587



1-866-432-5849

YOU DO NOT HAVE TO MAKE ANY PAYMENT TO THE HOSPITAL UNTIL THE HOSPITAL SENDS YOU A LETTER WITH ITS DECISION ON YOUR APPLICATION

