For Internal use only
Account #_____
Amount of W/O $_____

NYU Faculty Group Practice
Financial Assistance Application

Please mail or fax completed application to:

NYU Physician Services
P.O. Box 415662
Boston, MA 02241
Fax #: 646-754-7566

Patients treated in the NYU Langone Medical Center Faculty Group Practice (FGP) are responsible for paying all applicable out-of-pocket costs associated with their care including copayments, co-insurances and/or deductibles.

The FGP Financial Assistance Program provides discounts for low-income individuals who do not have health insurance or who have exhausted their health insurance benefits and meet certain income guidelines for eligible services. Exclusions to this program include, but are not limited to, non-covered services and elective procedures for patients who are enrolled in insurance plans which providers do not contract with.

To be eligible, a patient must be a US citizen or legal resident living in New York State or the state in which the service is rendered. All applications will be reviewed and approved on a case-by-case basis.

Patient Information

Name (Last, First, MI)			Date of Request	
Street Address		City	State	Zip
Home Phone ( ) Preferred ☐		Work Phone ( ) Preferred ☐	Cell Phone ( ) Preferred ☐	
SSN	Date of Birth	Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Partner ☐ Other:		
Citizenship		Current Insurance Status ☐ Insured ☐Uninsured ☐ Applying for a Government Program ☐ Other:		

Financial Information

Patient Employment Status ☐ Full-time ☐ Part-time ☐ Unemployed ☐ Retired ☐ Other:		**Guarantor** Employment Status ☐ Full-time ☐ Part-time ☐ Unemployed ☐ Retired ☐ Other:
Last Day Worked (if applicable)		Last Day Worked (if applicable)
Monthly Salary/Unemployment/Disability Income		Monthly Salary/Unemployment/Disability Income
Other Monthly Income (Rental, Investment, Pension or Other)		Other Monthly Income (Rental, Investment, Pension or Other)
Spouse Employment Status ☐ Full-time ☐ Part-time ☐ Unemployed ☐ Retired ☐ Other:		Comments:
Last Day Worked (if applicable)		
Monthly Salary/Unemployment/Disability Income		
Other Monthly Income (Rental, Investment, Pension or Other)		
Household Size	Total Household Income	

Complete Applications must include proof of income which can include:

1. Copies of pay stubs
2. Most recent W2 Forms and/or 1099s
3. Copy of application materials submitted to hospital patient financial services
4. Unemployment Documentation
5. Most Recent Tax Return
6. Copies of Medicaid, Family Health Plus or Child Health Plus application materials
7. Letter of support
8. Other Supporting Documents

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 understand that incomplete applications are unable to be processed.* 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.

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

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

By signing below, I acknowledge that the information I provided is correct to the best of my ability.

Patient Signature: _____ Date: _____/_____/_____

Guarantor Signature (if other than patient):_____ Date: _____/_____/_____

Please contact our customer service team at 1-877-648-2964 with questions about your application