**For Administrative use only**
Facility ***NYU Long Island***

Account # _____

Med.Rec# _____

# Financial Assistance Application

(Attachment A)

**For Administrative use only**
Patient Type _____

Amount of W/O $_____

Method of Calculation _____

## 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:** *(Circle One)* | **Married** | **Single** | **Separated** | **Total Number in Household:** |
|---|---|---|---|---|

| **Spouse & Dependent Name(s):** *(Attach separate sheet for additional dependents)* | **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** |
|---|---|
| | ***Hire Date:*** |
| | ***Hire Date:*** |
| | ***Hire Date:*** |

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

| **Are you covered by or are you applying for any health insurance (Including Medicaid and NY State of Health plans)?** | **YES** | **NO** |
|---|---|---|
| **If yes, please explain:** *(include insurance company name, address, telephone number, policy/group number and subscriber information)* | | |

## V. Other Information

| **Is treatment the result of an accident or injury?** | **YES** | **NO** |
|---|---|---|
| **If Yes, date of accident:**<br>**Brief description of the accident:**<br>**Street, City and State of accident:**<br>**Will a homeowner's or liability insurance be involved?** | | |

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

## 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 Langone Hospital-Long Island 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 _____

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

NYU Langone Hospital-Long Island Financial Assistance Application Enclosed:

PROCESS FOR APPLYING FOR FINANCIAL ASSISTANCE:

1. Complete the enclosed application in its entirety

2. Return the completed application within 30 days to:

   NYU Langone Hospital- Long Island
   259 First Street
   Mineola, NY, 11501
   Attn: Financial Assistance

3. After all items are received your request will be reviewed and you will be notified in writing of your determination within 30 days

**IMPORTANT**

- This financial assistance application is for hospital charges and does not cover doctor or other professional charges.
- Private room or other personal item charges are not covered by the financial assistance program
- Elective services covered by insurance not accepted by NYU Langone Hospital- Long Island are not covered by the Financial Assistance Program

If you have any questions please do not hesitate to reach us at (516) 663-8373

Sincerely;

Financial Counseling Services

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