NYU Langone Hospitals Financial Assistance Application Enclosed

PROCESS FOR APPLYING FOR FINANCIAL ASSISTANCE:

1. Complete the enclosed application in its entirety
2. Return the completed application within thirty (30) days to:

   NYU Langone Hospital - Brooklyn
   150 55th Street, Suite LB 2840
   Brooklyn, NY 11220

   (718) 630-6252

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

IMPORTANT:

- ***No documentation to show proof of income or paid medical expenses is required when submitting this application***
- This financial assistance application is for hospital charges only and does not cover physician or other professional charges
- Private room and other personal item charges are not covered by the Financial Assistance Program
- Cosmetic procedure charges are not covered by the Financial Assistance Program
- Elective services covered by insurance plans not accepted by NYU Langone Hospitals are not covered by the Financial Assistance Program

If you have any questions, please do not hesitate to contact us at (718) 630-6252.

Sincerely,

Financial Counseling Services

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

NYS Uniform Hospital Financial Assistance Application

You may be eligible for hospital financial assistance to pay your bills if you are uninsured, if your insurance is exhausted, or if you have health insurance but have proof of paid medical expenses totaling more than 10% of your income. Completing this form will start your request for hospital financial assistance. This form is used by all hospitals in New York State.

This application must be printed in the primary[1] languages spoken by patients served by the hospital.

Patient Name (complete information that is applicable)

Patient Name (First, Middle, Last)		
Date of Birth (mm/dd/yyyy)		
Address	Apartment/Unit #	
City	State	Zip
Contact Phone #		
Parent/Guardian or Lawful Representative Name (if patient is a minor child or an incapacitated adult)		
Email Address (if any)		

Family Information:

Please list below all family members in your household. Your household includes yourself, your spouse or domestic partner, and any children or other dependents. For example, this would include everyone listed on the same tax return.

Gross income means your income **before** taxes are deducted.

Gross income can consist of work earnings (wages, salaries, tips, earnings from self-employment), unearned income (social security, disability, and unemployment benefits), contributions (funds from family or friends), and other sources of income (temporary assistance and supplemental security income).

Full Name	Relationship	Total Gross Income (Current)
	Self	

[1] "Primary languages" includes any language that is used to communicate in at least 5% of patient visits per year, or any language spoken by more than 1% of the primary hospital service area population as calculated using demographic information available from the United States Bureau of the Census, supplemented by data from school systems.

The hospital may request you submit documentation as proof of income; examples of documentation might include a pay stub, a letter from your employer if applicable, or Form 1040.

Health Insurance Status

Do you have any form of health insurance, including Medicaid, Medicare, or private insurance through your employer or purchased on your own? ☐ Yes ☐ No

If you answered "No," would you like assistance in applying for any of these programs?

☐ Yes ☐ No

Underinsured patients: people with insurance and high medical expenses.

If you have insurance, please provide an estimate of the medical bills you paid in the past 12 months

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The hospital may request you submit documentation as proof of paid medical expenses.

Patient/Responsible Party: If not the patient, list the name of the person signing the form and their authority to sign on behalf of the patient (e.g., spouse, parent, legal representative).

I understand that the information I submit may be subject to verification from external sources. I certify that the information is true and complete to the best of my knowledge.

Print Name Relationship to Patient	Date
Signature	