I. Summary of Policy

This policy outlines the guidelines through which low-income individuals who do not have health insurance or who have exhausted their health insurance benefits and who can demonstrate an inability to pay for their care may receive financial assistance from NYU Langone Health – Florida, Inc. D/B/A NYU Langone Health Ambulatory Surgery Center ("NYULH-Florida") for medically necessary services provided at its ambulatory surgical center(s).

II. Policy Purpose

The purpose of this policy is to facilitate access to medically necessary care for low-income individuals and to define the requirements to qualify for financial assistance.

III. Applicability of the Policy

This policy applies to all NYULH-Florida locations, including each ambulatory surgical center licensed in Florida to NYULH-Florida. It applies to facility charges billed by NYULH-Florida and does not apply to professional fees billed separately by physicians or other health care providers. Professional fees billed by NYU Grossman School of Medicine Faculty Group Practice for services at the ASC are governed by the Faculty Group Practice Financial Hardship and Charity Care Policy (Policy Number FGP-SP-1).

IV. Policy

Patients receiving services at NYULH-Florida are responsible for paying all applicable out-of-pocket costs associated with their care, including copayments, co-insurances and deductibles, and self-pay fees. At no time may NYULH-Florida or its staff advertise or communicate that payments from commercial insurance carriers, Medicare, or Medicaid will be accepted as payment in full or otherwise communicate that patients will not incur any out-of-pocket expenses. Based on the applicant's circumstance, NYULH-Florida provides monthly payment plan arrangements or financial assistance discounts that may be available on a case-by-case determination.

Patients who are U.S. citizens or legal residents residing in Florida and who have demonstrated an inability to pay for medically necessary care may apply for financial assistance for their NYULH-

Florida open balances. The discount amount will be based on federal poverty guidelines established by the United States Department of Health and Human Services for the given year (Appendix A).

The NYULH-Florida Central Billing Office (CBO) will review and approve all applications. The Financial Assistance will be approved for three (3) months, but patients on fixed income such as Social Security Income and Disability will be approved for six (6) months. The effective date will be the date of service of the oldest balances owed, and the expiration date will be three (3) months from the date it's reviewed. Determinations will be based on documentation provided by the patient and/or their representatives. Exceptions to this policy are listed in Appendix B. The Vice President for Revenue Cycle or designee will approve all exceptions.
NYULH-Florida will post this policy, the Financial Assistance Application, and the NYULH-Florida Collecting Patient Balances Policy on the ASC website, together with information on how to apply for financial assistance, payment plans, and discounts.

V. Procedure

A. Patients and/or their representatives will express hardship to the customer service department.

B. The customer service representative will offer payment options. If the patient cannot meet the payment requirements, they will be referred for financial assistance screening, and a Financial Assistance Application will be sent to the patient.

C. Patients and/or their representatives will be asked to complete a Financial Assistance Application (**Appendix C**) and to provide proof of current income, which may include:

1. Copies of pay stubs for the past month
2. Most recent W2 Forms and/or 1099s
3. Unemployment Documentation
4. Most Recent Tax Return
5. Social Security Income / Disability

D. The CBO will suspend billing the patient during the financial assistance review process.

E. If an incomplete or missing application is received from the patient, NYULH-Florida will not process the application. A response letter will be sent, and billing will resume.

F. CBO will evaluate documentation within thirty (30) business days of receipt, and a determination will be made by reviewing a completed financial assistance application and all other supporting documentation.

G. Upon determination, the CBO will send a final decision letter for financial assistance outcome, along with a revised billing statement.

H. The customer service staff will apply the financial assistance discount to the patient's total balance if approved for financial assistance.

I. Billing will resume for any outstanding balance after applying the financial assistance discount.

J. Any unpaid balances will be handled in accordance with the NYULH-Florida Collecting Patient Balances Policy. Collection procedures, including any collection action, are governed by that policy and are not addressed in this policy.

K. The patient's billing record will include the financial assistance application, supporting documents, and approval indicator, including discount amount, approval, and expiration dates.

VI. Policy Enforcement

The Vice President for Revenue Cycle is generally responsible for implementing this policy. He/she may delegate responsibility for education and oversight to his/her staff members. The ASC Administrator is responsible for implementing this policy at the ASC.

VII. Related Policies

- NYULH-Florida Collecting Patient Balances Policy

VIII. Appendices

Appendix A: Current year's Federal Poverty Guidelines – enclosed

Appendix B: Exclusions to the NYULH-Florida Financial Hardship Policy – enclosed

Appendix C: NYULH-Florida Financial Assistance Application

Appendix A

FGP Financial Hardship Income Guidelines								
If household income level is equal to or less than:								
% of Federal Poverty Level	2026 Income for 1 Person Family	2026 Income for 2 Person Family	2026 Income for 3 Person Family	2026 Income for 4 Person Family	2026 Income for 5 Person Family	2026 Income for 6 Person Family	2026 Income for 7 Person Family	Discount
100%	15,960	21,640	27,320	33,000	38,680	44,360	50,040	100%
200%	31,920	43,280	54,640	66,000	77,360	88,720	100,080	75%
300%	47,880	64,920	81,960	99,000	116,040	133,080	150,120	50%
400%	63,840	86,560	109,280	132,000	154,720	177,440	200,160	0%

FPL Data Source: https://aspe.hhs.gov/poverty-guidelines

For families/households with more than 8 persons, add $5,680 for each additional person.

The 2026 poverty guidelines are in effect as of January 15, 2026

Appendix B: Exclusions to the NYULH-Florida Financial Hardship Policy

The following services across all NYULH-Florida locations are excluded from financial assistance discount:

1) Cosmetic procedures
2) Elective non-covered services
3) Certain Bariatric Procedures
4) Out-of-Network services
5) Medication
6) Any custom supplies or materials purchased on behalf of the patient
7) Other services designated by the Vice President for Revenue Cycle and listed in the current version of this Appendix posted on the ASC website

Financial Assistance Application (Appendix C)

NYU Langone Health – Florida, Inc. D/B/A NYU Langone Health Ambulatory Surgery Center Financial Assistance Application

Thank you for your interest in NYU Langone Health – Florida, Inc. ("NYULH-Florida") Financial Assistance Program.

The program may help reduce eligible facility charges for services provided at NYU Langone Health Ambulatory Surgery Center if you have a low income and meet the program requirements. You must be a U.S. citizen or legal resident residing in Florida.

You may qualify if you:

- Do not have health insurance
- Do not have enough insurance coverage
- Have used all available insurance benefits
- Have out-of-pocket costs, such as copays, coinsurance, or deductibles

Some services and balances are not covered by this program. These include, but are not limited to:

- Cosmetic procedures
- Elective non-covered services
- Certain bariatric procedures
- Out-of-network services
- Medication
- Any custom supplies or materials purchased on behalf of the patient
- Other services designated by the Vice President for Revenue Cycle and listed in the current version of the exclusions appendix posted on the ASC website

This Financial Assistance Application is governed by the **NYU Langone Health – Florida, Inc. Financial Hardship and Charity Care Policy**. Financial assistance applies to eligible facility charges billed by NYULH-Florida for services provided at the NYU Langone Health Ambulatory Surgery Center. It does not apply to professional fees billed separately by physicians or other health care providers.

You must complete all sections of the Financial Assistance application. We will review your application and documents using the current federal poverty guidelines issued by the U.S. Department of Health and Human Services. **Please submit the completed application and all required supporting documents as soon as possible.** Incomplete applications or applications with missing documents cannot be reviewed .

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Patient Information:

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

Proof of Legal Status:

Status	**Document Requirements**
□ **US Citizenship**	Valid U.S. Passport or Passport Card; **Or** State-Issued Enhanced/Real ID (Contains a flag or star symbol on front of card); **Or** U.S. Civil-Issued Birth Certificate; **Or** Certificate of Naturalization or Citizenship
□ **Legal Resident**	Form I-551 (Green Card); **Or** Temporary I-551 Stamp inside valid foreign passport, issued by U.S. Citizenship and Immigration Services; **Or** Foreign Passport with an I-551 Endorsement; **Or** Eligible Immigrant Visa

Family Information:

Please list 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).

Household Member Full Name	Relationship	Total Gross Income (Current)
	Self	

Document Requirements for Proof of Household Size: (Required for all applicants)

- Most recent Federal Tax Return showing number of dependents; **Or**
- Government Benefits Award letters (SNAP, Medicaid, or WIC), which show verified household size, **Or**
- Birth Certificates / Adoption Certificates for dependent children or Marriage Certificates

Proof of Income Documents:

Please include the income information for the patient, their spouse, and any dependents (such as children). For example, this would include everyone on the same tax return (tax filer, spouse, and tax dependents) in the calculation of household income.

The following is a list of documents you can use to prove your income. You may also provide a statement of no household income if you have no income.

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Please submit all proof of income that pertains to the Household.

If Household Receives:	**Gross Amount per Month:**	**Applicant May Provide:**
Alimony/Child Support	**$**	Copy of court order; **Or** Three months of cashed checks/receipts
Dividends/Interest	**$**	Quarterly dividends statements; **Or** Most recent monthly statement
No Income	**$0**	Signed Statement of no income
Retirement/Pension	**$**	Most recent 1099-R Form for pensions, annuities, retirement, profit sharing plans, 401(k), and/or IRAs; **Or** Most recent Federal 1040 Tax Form
Social Security Payments or Disability Payments	**$**	Social Security Benefit Verification Letter; **Or** Social Security Notice of Award Letter; **Or** Most recent Form SSA – 1099 – Social Security Benefit Statement; **Or** Most recent Federal 1040 Tax Form
Students	**$**	Current school transcripts for full-time college or university students
Unemployment Compensation	**$**	Copy of an unemployment-benefit award letter, certificate, or monthly benefit statement from the applicable state workforce agency; **Or** Copy of a direct-deposit payment card or payment record, with supporting account information; **Or** Correspondence from the applicable state workforce agency or a printout of the applicant's unemployment-benefit account information.
Wages	**$**	Copies of consecutive pay stubs for the past month (2 paystubs if paid biweekly, or 4 paystubs if paid weekly); **Or**

		Letter from Employer on company letterhead, signed and dated; **Or** Most recent W2 Form, Federal 1040 Tax Form, and/or 1099 Form for self-employed applicants
Workers Compensation	**$**	Copy of Award Letter; **Or** Check Stub
Other	**$**	Letter of Support stating the amount of non-wage earnings, such as rental income, cash for odd jobs, etc.

**To request a copy of your Social Security benefit letter, call 1-800-772-1213 or visit www.ssa.gov*

Please send the completed application and supporting documents by any of the methods below:

- **MyChart:** Send a message and attach your documents via your MyChart account to NYU Langone Physician Billing
- **Mail:**
  NYU Grossman School of Medicine
  Faculty Group Practice
  P.O. Box 415662
  Boston, MA 02241
- **Fax #:** (646)754-7566
- **Email:** NYUPatientBilling@nyulangone.org

Certification

I certify that the above information is true and accurate to the best of my knowledge. I also certify that the information entered into the application coincides with my supporting documents. I understand that fraudulent or misleading information will make me ineligible for financial assistance. I understand that incomplete applications or missing supporting documents cannot be processed. I authorize the release of any information needed to verify the information provided and billing and collections in compliance with applicable federal and state laws.

I understand that this application is made so that NYULH-Florida can determine my eligibility for financial assistance based on the established criteria on file.

In addition, I agree to provide additional information as requested to determine eligibility within 30 days. I agree to inform NYULH-Florida of any change in insurance eligibility, income, living arrangements, or address.

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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: _____ /_____/_____

Important: The application will be considered incomplete if it is not signed and dated.