NYU Tisch Hospital/NYU Orthopedic Hospital 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 Hospitals Center
   Financial Counseling Services
   560 First Avenue, SK-133
   New York, NY 10016

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

IMPORTANT:

- This financial assistance application is for Hospital Charges only and does not cover doctor or other professional charges
- Private room or 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 not accepted by NYU Hospitals Center are not covered by the Financial Assistance Program

If you have any questions please do not hesitate to contact us at (866)486-9847.

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

For Administrative use only
Facility_____

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, Child Health Plus, Essential Plan , or Qualified Health Plan)?	**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: **Brief description of the accident:** **Street, City and State of accident:** **Will a homeowner's or liability insurance be involved?**		

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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 _____

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