

## Financial Assistance Application Instructions

The Northwell Health Financial Assistance Program is designed to help patients who have received medically necessary services but are uninsured or have exhausted their benefits for a particular service. Eligibility for the program is based on current income and is available to individuals with household incomes that are less than those shown below:

Household / Family Size	Maximum Household Income (500% 2018 of Federal Poverty Level)
1	\$60,700
2	\$82,300
3	\$103,900
4	\$125,500
5	\$147,100
6	\$168,700
For each additional person, add	\$21,600

When completing an application for Financial Assistance please remember the following:

- An application is not complete until all Required Documentation is received. An incomplete application **will not** be reviewed and the normal billing cycle will continue.
- **Required Documentation** – attach copies of checks, pay stubs or statements that support any of the types of income that are reported on your financial assistance application. In addition, please provide copies of all bills or statements that you would like reviewed as part of your application. Note that we reserve the right to request additional documentation related to assets for patients with household incomes under 150% of the Federal Poverty Level.
- Once we receive your completed application, you can disregard any bills / statements until you receive written notification regarding the status of your financial assistance application.
- Applicants for financial assistance are expected to fully cooperate in applying for any government sponsored health insurance program (e.g., Medicaid, Child Health Plus, etc.) that Northwell Health believes you may be eligible for.
- Please mail your application to: Northwell Health  
 Financial Assistance Unit  
 PO Box 9001  
 Melville, NY 11747-9001

**For more information please call 1.800.995.5727**

## FINANCIAL ASSISTANCE APPLICATION

**Applicant's Information:**

Applicant's, Parent, Guardian Name \_\_\_\_\_ Social Security Number \_\_\_\_\_ DOB: / / Preferred Language \_\_\_\_\_

Applicant's Home Address City State Zip Code \_\_\_\_\_

( ) - Cell, Home, Work Phone Number ( ) - Cell, Home, Work Phone Number Email Address \_\_\_\_\_

**Patient's Information:**

Patient's Name \_\_\_\_\_ Social Security Number \_\_\_\_\_ DOB: / /

Patient's Relationship to Applicant:  Self  Spouse/Partner  Parent/Legal Guardian  Child  
 Other: \_\_\_\_\_  
Please Specify \_\_\_\_\_

**PLEASE STATE THE NORTHWELL HEALTH FACILITY THAT THE PATIENT HAS OUTSTANDING BILLS WITH:**

Approximate Date of Service: \_\_\_\_\_ Account Number(s): \_\_\_\_\_

**Total Household Size: List the dependents who reside in the applicant's house for which the applicant takes financial responsibility. Check the appropriate box for each dependent.**

Name	Age	Relationship			
		Spouse/Partner	Parent	Child	Other
1. _____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. _____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. _____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. _____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. _____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Total Gross Monthly Income for the last 30 days:**

Sources of Income	Applicant/Patient	Spouse/Live-in Partner
Wages	\$ _____	\$ _____
Social Security Payment	\$ _____	\$ _____
Unemployment Compensation	\$ _____	\$ _____
Disability Payment	\$ _____	\$ _____
Workers Compensation	\$ _____	\$ _____
Alimony/Child Support	\$ _____	\$ _____
Dividends, Interests, Rental Income	\$ _____	\$ _____
Other	\$ _____	\$ _____

Please provide copies of checks, paystubs, or statements to support all reported income.

I allow a health insurance representative to contact me to assist me in applying for government sponsored health insurance.

Best time to be reached:  Morning  Afternoon  Evening  Weekend  Anytime  Do NOT contact me

I certify that the information and documentation provided and that the answers given are truthful and accurate. My failure to pay any reduced or adjusted balance will subject me to the normal billing and collection practices of the Northwell Health.

X \_\_\_\_\_ / /  
Applicant/Patient Signature (Parent/Legal Guardian for minor child) Date

**Mail Completed Application to: Northwell Health Financial Assistance Unit, P.O. Box 9001, Melville, NY 11747-9001**