

Enstriksyon pou fè aplikasyon pou asistans finansye (Financial Assistance Application Instructions)

Pwogram asistans finansye Northwell Health la fèt yon fason pou l ede pasyan ki te resevwa sèvis ki medikalman nesèsè men yo pa gen asirans oswa yo te epuize benefis yo pou yon sèvis an patikilye. Yo baze elijiblite pou pwogram nan sou revni aktyèl pasyan an epi pwogram nan disponib pou moun kote revni fanmi yo mwens pase sa ki endike anba a:

Gwosè mezone/fanmi an	Revni maksimòm fanmi an (500% nivo povrete federal la pou 2018)
1	\$60,300
2	\$81,200
3	\$102,100
4	\$123,000
5	\$143,900
6	\$164,800
Pou chak moun sipleman, ajoute	\$20,900

Lè w ap ranpli yon aplikasyon pou asistans finansye tanpri sonje sa ki site la a:

- Yon aplikasyon pa konplè pazavan nou resevwa tout dokiman ki obligatwa yo. Nou **pa pral** egzamine yon aplikasyon ki pa konplè epi peryòd faktirasyon nòmal la pral kontinye.
- **Dokiman ki obligatwa** – atache kopi chèk, souch chèk oswa deklarasyon ki sipòte nenpòt nan tip revni ou rapòte sou aplikasyon pou asistans finansye w la. Anplis de sa, tanpri ban nou kopi tout fakti oswa deklarasyon ki fè pati aplikasyon w lan ou ta renmen nou egzamine. Note nou rezève dwa nou pou n mande w lòt dokiman ki gen rapò ak byen pou pasyan ki gen revni ki pi ba pase 150% nivo povrete federal la.
- Yonfwa nou fin resevwa aplikasyon ou fin ranpli a, ou ka iyore nenpòt fakti / deklarasyon ou resevwa jiskaske ou resevwa notis alekri konsènan estati aplikasyon pou asistans finansye w la.
- Nou atann pou moun ki fè aplikasyon pou asistans finansye koopere nèt lè y ap aplike pou nenpòt pwogram asirans sante gouvènman an patwone (pa egzanp, Medicaid, Child Health Plus, eksetera) epi Northwell Health kwè ou ka elijib pou jwenn.
- Tanpri voye aplikasyon w lan pa lapòs nan:

Northwell Health
 Financial Assistance Unit
 PO Box 9001
 Melville, NY 11747-9001

Pou plis enfòmasyon tanpri rele 1.800.995.5727

APLIKASYON POU ASISTANS FINANSYE (FINANCIAL ASSISTANCE APPLICATION)

Enfòmasyon kandida a:

Non kandida a, paran, gadyen _____ Nimewo sekirite sosyal _____ Dat nesans: Mwa Jou Ane _____ Lang prefere _____

Adrès kay kandida a Vil Eta Kòd postal
(_____) _____ - _____ (_____) _____ - _____

Nimewo telefòn selilè, lakay, travay _____ Nimewo telefòn selilè, lakay, travay _____ Adrès imèl _____

Enfòmasyon pasyan an:

Non pasyan an _____ Nimewo sekirite sosyal _____ Dat nesans: Mwa Jou Ane _____

Relasyon pasyan an ak kandida a: Mwen menm Konjwen/patnè Paran/gadyen legal Pitit
 Lòt: _____

Tanpri presize

TANPRI METE ETABLISMAN NORTHWELL HEALTH PASYAN AN GENYEN FAKTI KI POKO PEYE:

Dat sèvis apwoksimatif: _____ Nimewo kont (yo): _____

Gwosè total fanmi an: Site depandan ki abite nan kay kandida a epi ki sou responsablite finansye kandida a. Tyeke bwat ki apwopriye pou chak depandan.

Non	Laj	Relasyon			
		Konjwen/patnè	Paran	Pitit	Lòt
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"/>

Revni mansyèl brit total pou 30 jou ki sot pase yo:

Sous revni	Kandida/pasyan	Konjwen/patnè domestik
Salè	\$ _____	\$ _____
Pèman sekirite sosyal	\$ _____	\$ _____
Konpansasyon pou chomaj	\$ _____	\$ _____
Pèman envalidite	\$ _____	\$ _____
Konpansasyon pou aksidan travay	\$ _____	\$ _____
Pansyon alimantè/pansyon alimantè pou timoun	\$ _____	\$ _____
Dividann, enterè, revni lokasyon	\$ _____	\$ _____
Lòt	\$ _____	\$ _____

Tanpri bay kopi chèk,
souch chèk oswa
deklarasyon ki sipòte
tout revni ou rapòte yo.

Mwen pèmèt pou reprezantan asirans sante a kontakte m pou ede w aplike pou asirans sante gouvènman an patwone. Lè ki pi bon pou kontakte m: Maten Aprèmidi Aswè Wikenn Nenpòt lè PINGA kontakte m
Mwen sètifye enfòmasyon ak dokiman mwen bay yo ak respons mwen bay yo se laverite epi yo egzat. Si mwen pa peye nenpòt balans kòb ki redui oswa ki ajiste mwen pral sijè a faktirasyon nòmal ak pratik koleksyon Northwell Health ka fè.

X _____ / _____ / _____
Siyati kandida/pasyan (Paran/gadyen legal pou timoun ki minè) _____ Dat _____

**Voye aplikasyon ki fin konplete a pa lapòs nan:
Northwell Health Financial Assistance Unit, P.O. Box 9001, Melville, NY 11747-9001**

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 _____ / / _____ 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 _____ / / _____

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