Northwell Health

# 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% of Federal Poverty Level) |
|---|---|
| 1 | $58,850 |
| 2 | $79,650 |
| 3 | $100,450 |
| 4 | $121,250 |
| 5 | $142,050 |
| 6 | $162,850 |
| For each additional person, add | $20,800 |

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<br>Financial Assistance Unit<br>PO Box 9001<br>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: Mo Day Year — 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: Mo Day Year

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. __________________________________ | _____ | ☐ | ☐ | ☐ | ☐ |
| 2. __________________________________ | _____ | ☐ | ☐ | ☐ | ☐ |
| 3. __________________________________ | _____ | ☐ | ☐ | ☐ | ☐ |
| 4. __________________________________ | _____ | ☐ | ☐ | ☐ | ☐ |
| 5. __________________________________ | _____ | ☐ | ☐ | ☐ | ☐ |

**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**