NEWYORK – PRESBYTERIAN HOSPITAL FINANCIAL AID POLICY SUMMARY

NewYork-Presbyterian Hospital has a long-standing policy to assist patients who receive health care services at our hospital and are in need of financial aid, regardless of age, gender, race, national origin, socio-economic or immigrant status, sexual orientation or religious affiliation.

IF YOU HAVE A FINANCIAL OBLIGATION TO NEW YORK – PRESBYTERIAN HOSPITAL (HOSPITAL), AND BELIEVE YOU CANNOT AFFORD TO PAY, NYPH HAS A FINANCIAL AID POLICY WHICH CAN ASSIST QUALIFIED PATIENTS.

HOW DO I KNOW IF I QUALIFY FOR FINANCIAL AID?

- Residents of New York State may qualify for Financial Aid for medically necessary emergency services.
 Residents of Hospital's primary service area may qualify for Financial Aid for medically necessary non-emergency services.
- For NewYork-Presbyterian/Columbia (including Morgan Stanley Children's Hospital of NewYork-Presbyterian), NewYork-Presbyterian/Weill Cornell, NewYork-Presbyterian/Lower Manhattan and NewYork-Presbyterian/Allen, the primary service area consists of the five boroughs (counties) of New York City.
- For NewYork-Presbyterian/Westchester, the primary service area consists of the following counties: Westchester, Bronx, Orange, Putnam and Rockland.
- Patients who meet the above criteria and have incomes below the amounts shown below may be eligible for Financial Aid.

PERSONS IN FAMILY OR HOUSEHOLD	INCOME (EFF. 2/1/2021) \$77,280		
1			
2	\$104,520		
3	\$131,760 \$159,000		
4			
FOR EACH ADDITIONAL PERSON, ADD:	\$27,240		

- Financial Aid eligibility generally will be determined upon completion of a Financial Aid application.
- This Policy does NOT apply to the charges of physicians or other providers who bill independently for their services. Hospital's ACN (clinic) providers ARE covered by the Financial Aid Policy.

WHAT KIND OF ASSISTANCE CAN I GET?

- Hospital will not charge patients eligible for its Financial Aid program more than amounts generally billed (AGB), to individuals who have insurance for emergency or other medically necessary care. For all other care, an eligible individual may not be charged more than Hospital's gross charges. The Hospital calculates the AGB using the prospective method, and bases that rate on current New York State fee-for-service Medicaid rates.
- An installment payment plan will be made available to eligible patients.
- Once your application has been submitted, you may disregard any bills until we have rendered a decision on that application.

HOW CAN I APPLY OR GET ANSWERS TO MY QUESTIONS?

- The Financial Aid Policy, Summary, and application are available at our Admitting Offices or on our website at www.nyp.org under the Pay My Bill/Financial Aid button in English and other languages
- Information regarding eligibility for Financial Aid and the application process is available from the Admitting Offices or by calling us toll-free at (866) 252-0101

NEWYORK-PRESBYTERIAN HOSPITAL APPLICATION FOR FINANCIAL AID

Patient's Name Date of Birth					
Last	First	Middle Init			
Address					
AddressNumber and Street, Apt. #		City		State	Zip
Telephone No. ()	Occupation		Employer		
Employer Address		Employer Tel #			
Toronto Y	8 management in the second of the second	II d. h. d. d.t.	ecove C		
Income – List combined income for		Total Last 3 Months	bers from:	Total Last 12 Mont	ha
		Total Last 3 Months		Total Last 12 Mont	IIS
Wages					
Self-employment Earnings					
Public Assistance					
Social Security					
Unemployment/Workers' Compens	ation				
Alimony					
Child Support					
Pensions					
Income From Dividends					
Total					
Family Size - Family members liv Name	ing in your household	: Age		Relationship	
Note: Please attach another sheet if	additional space need	ed.			
THIS APPLICATION MAY BE SUBMIT	TED TO THE HOSPIT	AL AT ANY TIME DURING	G THE BILLIN	G AND COLLECTION P	ROCESS.
ONCE YOU HAVE SUBMITTED A CO BELOW, YOU MAY DISREGARD ANY	MPLETED APPLICATI BILLS UNTIL THE H	ON AND SUPPORTING DO OSPITAL HAS RENDEREI	OCUMENTATI D A WRITTEN	ON TO THE HOSPITAL DECISION ON YOUR A	AT THE ADDRES PPLICATION.
TO SUBMIT THIS APPLICATION FOR BELOW.	FINANCIAL AID, PLE	EASE READ THE FOLLOW	ING STATEMI	ENT AND SIGN WHERE	INDICATED
I HEREBY REQUEST THAT NEWYOR FINANCIAL AID. I UNDERSTAND THE SUBJECT TO VERIFICATION BY THE TO BE FALSE, SUCH DETERMINATION SERVICES PROVIDED. I AFFIRM THE FURTHER, I HEREBY GIVE MY PERMITHIS APPLICATION.	IAT THE INFORMATION HOSPITAL. I ALSO UN WILL RESULT IN A THE INFORMATION OF THE INFORMATI	ON WHICH I SUBMIT CON INDERSTAND THAT IF TH A DENIAL OF FINANCIAL ON ABOVE IS TRUE AND C	NCERNING MY HE INFORMAT AID AND THA CORRECT TO T	Y ANNUAL INCOME AN TON WHICH I SUBMIT AT I MAY BE LIABLE FO THE BEST OF MY KNOV	ID FAMILY SIZE I IS DETERMINED OR CHARGES FOF WLEDGE.
Date Signatu	re of Applicant			Account #	
Completed Application to be sent to:		rk-Presbyterian Hospital Pati icho Quadrangle, Suite 202	ient Financial Se	ervices	

Jericho, NY 11753 Att: George Plunkett Or FAX to: (516) 801-8504