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	$60,300
2	$81,200
3	$102,100
4	$123,000
5	$143,900
6	$164,800
For each additional person, add	$20,900

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 (including North Shore University Hospital, Long Island Jewish Medical Center, Cohen Children's Medical Center, The Zucker Hillside Hospital, Huntington Hospital, Lenox Hill Hospital, Manhattan Eye, Ear and Throat Hospital, Staten Island University Hospital, Long Island Jewish Valley Stream, Long Island Jewish Forest Hills, Glen Cove Hospital, Plainview Hospital, Southside Hospital and Syosset Hospital)

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

Northwell Health

Northern Westchester Hospital Association
Patient Accounts Department
34 South Bedford Road, 2nd Floor
Mount Kisco, NY 10549-1096
914.666.1512

Phelps Memorial Hospital Association
Financial Counseling
701 North Broadway
Sleepy Hollow, NY 10591-1096
914.366.3133

Peconic Bay Medical Center
Financial Assistance Coordinator
1300 Roanoke Avenue
Riverhead, NY 11901
631.548.6099

For more information please call 1.800.995.5727