

Financial Assistance Application
(Attachment B)

VI. Financial Statement

Enter totals for Patient, Guarantor, Spouse and Dependents: (Add additional sheets as necessary)

<u>ASSETS:</u>	<u>VALUE:</u>	<u>MONTHLY INCOME:</u>	<u>AMOUNT:</u>
Checking Accounts	\$	Wages, Salaries, Tips	\$
Savings Accounts	\$	Social Security	\$
Certificates of Deposits (CDs)	\$	Disability	\$
Stocks/Bonds	\$	Unemployment	\$
Mutual Funds	\$	Child Support	\$
Money Market Accounts	\$	Alimony/Maintenance	\$
Other Investments (Specify):		Rental Income	\$
	\$	Property Income	\$
	\$	Pension	\$
	\$	Dividends/Interest	\$
Other Assets (Specify):		Other Income (Specify):	
	\$		\$
	\$		\$
	\$		\$

<u>MONTHLY EXPENSES:</u>	<u>AMOUNT:</u>
Rent/Mortgage	\$
Utilities (Electricity, Telephone, Cable, Water, Gas)	\$
Automobile Payments	\$
Daycare	\$
Child Support	\$
Charge/Credit Card	\$
Alimony	\$
Other Expenses (Specify):	
	\$
	\$
	\$
Total Outstanding Medical Bills	\$

REQUIRED DOCUMENTS (if applicable):

Provide for Patient, Guarantor, Spouse & Dependents:

- Identification (at least 1 of the following: Passport, Birth Certificate, Valid Driver's License, or Military Discharge Papers)
- Last 4 Pay Stubs or Unemployment Check stubs
- Social Security Award Letter
- Verifiable proof of Disability, Pension, Child Support, Alimony, and or Rental Income
- Copies of current Bank Statements for Checking, Savings, Stocks, Bonds, Mutual Funds, Money Markets, or any other Investment Account
- Verifiable Proof of Any Other Income
- Rent Statement or Payment Receipt
- Mortgage Statement
- Electricity, Telephone, Cable, Water, Gas Bills
- Outstanding Medical Bills

CERTIFICATION

I certify that the above information is true and accurate to the best of my knowledge. I understand that fraudulent or misleading information will make me ineligible for any financial assistance. I authorize the release of any information needed to verify the information provided and for billing and collections in compliance with applicable federal and state laws. Further, I will make application for any assistance (Medicaid, Medicare, Insurance, etc.) which may be available for payment of my hospital charges, and I will take any action reasonably necessary to obtain such assistance and will assign or pay to the hospital the amount recovered for hospital charges.

I understand that this application is made so that the hospital can determine my eligibility for Financial Assistance based on the established criteria on file in the hospital.

I authorize NYU Hospitals to obtain credit information, which may include a consumer credit report, and to release all information concerning my credit.

In addition, I agree to provide additional information as requested in order to determine eligibility. I agree to inform NYU Hospitals of any change in my needs, insurance eligibility, income, property, living arrangements or address as they occur.

Signature of Applicant: _____ Date _____
Signature of Interviewer: _____ Date _____
Signature of Director: _____ Date _____

New York State offers various low cost health insurance plans that are available for children, individuals, families and small businesses. Contact Information:



1-800-698-4543



1-877-934-7587



1-866-432-5849