NewYork-Presbyterian
Hudson Valley Hospital

Date: _____

Guarantor Name: _____

Address: _____

_____

Dear Sir/Madam:

As per your request, attached is the form to be completed for a financial assistance consideration. Please be sure to complete all questions on this form and return with all requested documentation within 20 days for review. Should you have any questions or should you need an extension to complete, please contact our Financial Counselor at 914-734-3518 or email us at pa@hvhc.org. Please do not submit the application to this email. Either mail the application or drop off at the hospital.

RETURN TO:

Financial Counselor
NewYork-Presbyterian Hudson Valley Hospital
1980 Crompond Road
Cortlandt Manor, NY 10567

If everything is in order we will process the application and send you a written response within 30 days. You will not be responsible for payment until a determination has been made by the hospital. Should there be any problems with the application, our financial counselor will contact you.

NEW YORK-PRESBYTERIAN HUDSON VALLEY HOSPITAL
1980 CROMPOND ROAD • CORTLANDT MANOR, NY 10567 • 914-737-9000 • www.hvhc.org

Confidential

New York Presbyterian Hudson Valley Hospital
Financial Assistance Application

Applicant's Name: _____ ***Date of Birth***: _____

Address: _____

_____

Phone: _____Account #_____

Patient's relationship to Applicant:

___Self ___Spouse/Partner ___Parent/Legal Guardian ___Child ___Other_____ (Please Specify)

Have you applied for Medicaid? _____Yes _____No If No, why not? _____

Total Household Size: (includes dependents who reside in the applicants house for whom the applicant takes financial responsibility

Name	Age	Relationship

Total Gross Income (income before taxes) for the last 90 days:

Sources of Income	Applicant's Income	Spouse/Partner Income
Wages		
Social Security payment		
Unemployment compensation		
Disability		
Workers compensation		
Alimony/child support		
Dividends/interest/rentals		
All other income (VA benefits, Public Assistance etc.)		
Total		

You must provide copies of checks, paystubs, or statements to support all reported income or you may be denied assistance

I certify that the information and documentation provided as well as all answers given are truthful and accurate. My failure to pay any reduced or adjusted balances will subject me to the normal billing and collections practices of New York Presbyterian Hudson Valley Hospital.

Signed_____ Date_____
Applicant/Patient Signature (Parent/Legal Guardian for minor child)

You do not have to make any payment to the hospital until the hospital sends you a letter with its decision on your application. We will respond within 30 days of your application if all information is provided at the time of the application. If there are questions, please call 914-734-3858 and ask for a financial counselor.

Mail Completed Application to: New York Presbyterian/Hudson Valley Hospital, ATTN: Financial Counselor, 1980 Crompond Road, Cortlandt Manor, NY 10567

05/01/2017

Documentation Required for Proof of Income

Please submit all forms of documentation that applies to you to be reviewed for possible charity care:

_____ Copies of current pay stubs (last 90 days)

_____ Unemployment insurance stubs

_____ Support payments (child support/alimony)

_____ Retirement benefits, Workers Compensation, Pensions

_____ Letter of support from responsible party, with income documentation

_____ Supporting documentation for dividends, interest, rental income

_____ Other sources of income (VA benefits, Public Assistance)

Any additional information that may help to determine your financial need may be included. This includes prior year's tax returns, monthly bills or any other information that will help support the need for financial assistance.

If you have any questions, please call 914-734-3858 and ask for a financial counselor.