NEWYORK-PRESBYTERIAN HOSPITAL
APPLICATION FOR CHARITY CARE

Patient's Name _____ Date of Birth _____
Last First Middle Init.

Address _____
Number and Street, Apt. # City State Zip

Telephone No. (_____)_____ Occupation _____ Employer _____

Employer Address _____ Employer Tel #_____

Income – List combined income for yourself, spouse, and all other household members from:

Type of Income	Total Last 3 Months	Total Last 12 Months
Wages		
Self-employment Earnings		
Public Assistance		
Social Security		
Unemployment/Workers' Compensation		
Alimony		
Child Support		
Pensions		
Income From Dividends		
Total		

Hospital requests that you submit documentation to substantiate the income you entered above. Examples of documentation might include pay stub, letter from employer if applicable, Form 1040, etc.

Family Size - Family members living in your household:

Name	Age	Relationship

Note: Please attach another sheet if additional space needed.

THIS APPLICATION MAY BE SUBMITTED TO THE HOSPITAL AT ANY TIME DURING THE BILLING AND COLLECTION PROCESS.

ONCE YOU HAVE SUBMITTED A COMPLETED APPLICATION AND SUPPORTING DOCUMENTATION TO THE HOSPITAL AT THE ADDRESS BELOW, YOU MAY DISREGARD ANY BILLS UNTIL THE HOSPITAL HAS RENDERED A WRITTEN DECISION ON YOUR APPLICATION.

TO SUBMIT THIS APPLICATION FOR CHARITY CARE, PLEASE READ THE FOLLOWING STATEMENT AND SIGN WHERE INDICATED BELOW.

I HEREBY REQUEST THAT NEWYORK-PRESBYTERIAN HOSPITAL MAKE A WRITTEN DETERMINATION OF MY ELIGIBILITY FOR CHARITY CARE. I UNDERSTAND THAT THE INFORMATION WHICH I SUBMIT CONCERNING MY ANNUAL INCOME AND FAMILY SIZE IS SUBJECT TO VERIFICATION BY THE HOSPITAL. I ALSO UNDERSTAND THAT IF THE INFORMATION WHICH I SUBMIT IS DETERMINED TO BE FALSE, SUCH DETERMINATION WILL RESULT IN A DENIAL OF CHARITY CARE AND THAT I MAY BE LIABLE FOR CHARGES FOR SERVICES PROVIDED. I AFFIRM THAT THE INFORMATION ABOVE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. FURTHER, I HEREBY GIVE MY PERMISSION TO NEWYORK-PRESBYTERIAN HOSPITAL TO VERIFY ANY INFORMATION PERTINENT TO THIS APPLICATION.

Date _____ Signature of Applicant _____ Account # _____

Completed Application to be sent to:

NewYork-Presbyterian Hospital Patient Financial Services
3 Expressway Plaza, Suite 200
Roslyn Heights, NY 11577
Att.: Jerome Fields
Or FAX to : (516) 801-8504