NewYork-Presbyterian
Medical Group Westchester

FINANCIAL ASSISTANCE PROGRAM APPLICATION

Patient Name_____Date of Birth_____

Address_____ City_____ State_____Zip_____

Home Phone #_____ Bus. Phone #_____Cell #_____

Marital Status_____

Employer (Patient) _____

Employer (Spouse)_____

If patient is a minor please include employment information of parent(s)

LIST HOUSEHOLD MEMBERS/DEPENDENTS

Name	Relationship	Age

Does anyone else claim you on their income tax: □ Yes □ No Who_____

ANNUAL INCOME Total income of all sources received by patient/spouse or parent (IF minor)

	Patient	Spouse	Mother	Father
Salary (Include overtime, tips, commissions, etc.)	$	$	$	$
Self-Employment Income				
Unemployment Income				
Social Security Income				
Disability Income				
Workers Compensation Income				
Pension/Retirement Income				
Rental/Boarder Income				
Alimony/Child Support				
Other				

CHECKING ACCOUNT(S)

Please provide a complete current copy of all checking accounts for patient as well as spouse's or parents' (if applicable) and return with application

I affirm by my signature below that the information contained in this application is true to the best of my knowledge. I agree to provide additional information as requested in order to determine eligibility.

_____ _____

APPLICANT SIGNATURE **DATE**

_____ _____

PARENT/GUARDIAN SIGNATURE **DATE**