NewYork-Presbyterian
Medical Group Brooklyn

New York Presbyterian Medical Group
APPLICATION FOR FINANCIAL ASSISTANCE

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		
Resources (bank accts., investments, loans, etc.)		
Total		

New York Presbyterian Physician Services Organization (NYPPSO) 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 NYPPSO AT ANY TIME BEFORE SERVICES ARE RENDERED OR DURING THE BILLING AND COLLECTION PROCESS.

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

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

I HEREBY REQUEST THAT NEW YORK PESBYTERIAN PHYSICIAN SERVICES ORGANIZATION (NYPPSO) MAKE A WRITTEN DETERMINATION OF MY ELIGIBILITY FOR FINANCIAL ASSISTANCE. I UNDERSTAND THAT THE INFORMATION WHICH I SUBMIT CONCERNING MY ANNUAL INCOME AND FAMILY SIZE IS SUBJECT TO VERIFICATION BY NYPPSO. I ALSO UNDERSTAND THAT IF THE INFORMATION WHICH I SUBMIT IS DETERMINED TO BE FALSE, SUCH DETERMINATION WILL RESULT IN A DENIAL OF FINANCIAL ASSISTANCE 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 NEW YORK PESBYRTERIAN PHYSICIAN SERVICES ORGANIZATION TO VERIFY ANY INFORMATION PERTINENT TO THIS APPLICATION.

Date_____Signature of Applicant_____Account #_____

Completed Application to be sent to: **New York Presbyterian Physician Services Organization**
1981 Marcus Ave., Suite 208, New Hyde Park, NY 11042 Attn: Customer Service or Fax: (718)661-0978