NewYork-Presbyterian
Medical Group Hudson Valley

New York Presbyterian Medical Group
APPLICATION FOR FINANCIAL ASSISTANCE

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 applicant's 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 Physician Services Organization – Hudson Valley.

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

You do not have to make any payment to the practice until you are sent a letter from the medical group providing the 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 914-739-2959 and ask for Customer Service.

Mail Completed Application to: NYPPSO-Hudson Valley, ATTN: Customer Service 1981 Marcus Ave., Suite 208, New Hyde Park, NY 11042 or by Fax: 718-661-0978