NYU Langone Hospital-Brooklyn Financial Assistance Application Enclosed:

PROCESS FOR APPLYING FOR FINANCIAL ASSISTANCE:

1. Complete the enclosed application in its entirety

2. Return the completed application within 30 days to:

   NYU Langone Hospital- Brooklyn
   Financial Counseling Services
   150 55th Street Suite LB 2940
   Brooklyn, NY 11220

3. After all items are received your request will be reviewed and you will be notified in writing of our determination within 30 days

IMPORTANT:

This financial assistance application is for Hospital Charges only and does not cover doctor or other professional charges
Private room or other personal item charges are not covered by the Financial Assistance Program

Financial Assistance Application

(Attachment A)

I. Patient Demographics

Patient Name:_____
(Last) (First) (Middle) (SSN ±NOT REQUIRED) (DOB)

Guarantor Name:_____
(Last) (First) (Middle) (SSN ±NOT REQUIRED) (DOB)

Address:_____
(S( )-5 792 re W* n BT /TT0 8.04 Tf 425.59 634.9 Td [(N)5.995 0(qd6.3 ir)17.003 (s)6.99 (t)-5 ())5 ( )-5 ( )9.005 (D_e TJ ET Q q 0

Are you covered by or are you applying for any health insurance (Including
Medicaid, Child Health Plus, (V V H Q W L D O 43XDDQ, lr H G + H D O W K 3 O D Q

Financial Assistance Application
(Attachment B)

VI. Financial Statement

Enter totals for Patient, Guarantor, Spouse and Dependents: (Add additional sheets as necessary)

MONTHLY INCOME:	AMOUNT:
Gross Wages, Salaries, Tips	$
Social Security	$
Disability	$
Unemployment	$
Child Support	$
Alimony/Maintenance	$
Rental Income	$
Property Income	$
Pension	$
Dividends/Interest	$
Other Income (Specify):	
	$
	$
	$

CERTIFICATION

I certify that the above information is true and accurate to the best of my knowledge. I understand that fraudulent or misleading information will make me ineligible for any financial assistance. I authorize the release of any information needed to verify the information provided and for billing and collections in compliance with applicable federal and state laws. Further, I will make application for any assistance (Medicaid, Medicare, Insurance, etc.) which may be available for payment of my hospital charges, and I will take any action reasonably necessary to obtain such assistance and will assign or pay to the hospital the amount recovered for hospital char-4(au) 0 g le for pa