Mather Hospital
Northwell Health®

Fortunato Breast Health Center

## Guidelines for Underinsured, Underserved Women's Fund

**You may be required to supply proof of statements made in this application, including identity, place of residence, income and resources.**

Patient's Name:_____ SS#:_____

Person Responsible for Bill:_____ SS#:_____

Address: _____ Phone:_____

Employer: _____Address: _____

Phone:_____ Position:_____ Salary:_____

Union or Local Affiliation:_____

Number of Dependents in Household:_____ Ages:_____

Do you have any Hospitalization Insurance? ❑ Yes ❑ No

If Yes, Is It: ❑ Medicare ❑ Medicaid ❑ Blue Cross ❑ Other, Specify: _____

**Please provide pages 1 & 2 of previous year's tax return.**

Please forward all applications to:
Mather Hospital
ATTN: Financial Assistance Department
75 North Country Road, NY 11777
Phone: 631.473.1320, ext. 4037
Fax: 631.686.7893

Date: _____ _____
Signature of Patient or Responsible Party