Mather Hospital
Northwell Health

Mather Hospital Financial Assistance Application

In order to determine whether or not you are eligible for financial assistance, we request this application be completed as thoroughly as possible. Please be advised that you are required to supply proof to support the statements made in this application including your identity, residence, income, and resources. (Attach additional pages if necessary.)

Patient's Name: _____
Address: _____
Applicant's Phone #: (___)_____-_____
Employer:_____
Address: _____ Phone #: (___)_____-_____
Position:_____ Salary:_____
Union or Local Affiliation:_____ Number of Dependents in Household: _____

Do you have any hospitalization insurance? Yes _____ No_____
If yes, Medicare: _____ Medicaid: _____ Blue Cross: _____ Other (specify) _____
Insurance Policy of Certificate #: _____

Name of Bank: _____ Address: _____
Savings Account: _____ Checking #: _____

Have you applied for Medicaid medical assistance? Yes_____ No _____
If yes, when: _____ Results: _____

I understand that by signing this document I am applying for Financial Assistance at Mather Hospital. I certify that the above information is true and accurate to the best of my knowledge. I also understand that Mather Hospital may verify the information I am providing and that deliberate falsification may disqualify my application from being considered for charity. I will cooperate with this verification and provide all needed evidence to support the information I have declared on this application.

Effective 2/1/1998, a Trans Union credit report may be required on specific Financial Assistance requests.

_____ _____

Signature of patient or responsible party *Date*