财务补助申请说明书
(Financial Assistance Application Instructions)

Northwell Health 财务补助计划旨在资助那些获得医疗必需服务但没有保险或用完某一具体服务福利的患者。符合该计划的资格是以当前收入状况为基础的，仅对家庭收入低于下列条件的个人提供：

家庭人口 / 家庭规模	最大家庭收入 （2022 年联邦贫困指南的 500%）
1	$67,950
2	$91,550
3	$115,150
4	$138,750
5	$162,350
6	$185,950
针对每一个额外的人口，增加	$23,600
* 显示 2022 年的数额，以供说明之用。必要时每年更新数额。	

在填写财务补助申请时请记住以下事项：

- 一份申请，在所有必需证明材料收到之前，将被视为未完成。未完成申请**不会**被审查，正常收费周期将持续下去。
- **必需证明材料** — 能证明您财务补助申请所报任何形式的收入的支票、薪资存根或月结单，请附上其备份件。此外，您想作为要审查的申请部分内容的所有账单或月结单，请提供其备份件。请注意：对于其家庭收入低于联邦贫困标准150%的患者，我们保留权利索要更多与资产有关的证明材料。
- 一旦我们收到您的完整申请，您可以不管任何账单/月结单，直到您收到关于您财务补助申请状况的书面通知。
- 要求财务补助申请人全面配合申请Northwell Health 公司认为您符合资格的任何政府资助健康保险计划（例如：Medicaid，Child Health Plus等）。
- 请将您的申请邮寄至：

  Mather Hospital Northwell Health
  Financial Assistance Unit
  100!Highlands Blvd Box 9
  Port Jefferson, NY 11777

若需更多信息，请致电631-476-2801 Option 1

Northwell Health®

财务补助申请
(FINANCIAL ASSISTANCE APPLICATION)

申请人信息：

_____ _____-_____-_____ _____/_____/_____ _____

申请人、家长、监护人的姓名　社会保障号码　出生日期：月 日 年　喜用语言

_____

申请人家庭地址、城市、州、邮政编码

(_____) _____-_____ (_____) _____-_____ _____

手机、住宅、工作电话　手机、住宅、工作电话　电邮信箱

患者信息：

_____ _____-_____-_____ _____/_____/_____

患者正楷姓名　社会保障号码　出生日期：月 日 年

患者与申请人关系：☐ 本人 ☐ 配偶/伴侣 ☐ 家长/合法监护人 ☐ 儿童 ☐ 其他：_____ 请注明

请声明患者在哪个NORTHWELL HEALTH 诊所有未付账单：

_____

大致服务日期: _____ 账号：_____

整个家庭人口：列出申请人家中居住的、申请人对其有财务责任的被赡养人。勾选每个被赡养人的相关复选框。

姓名	年龄	关系			
		配偶/伴侣	家长	孩子	其他
1. _____	_____	☐	☐	☐	☐
2. _____	_____	☐	☐	☐	☐
3. _____	_____	☐	☐	☐	☐
4. _____	_____	☐	☐	☐	☐
5. _____	_____	☐	☐	☐	☐

最近30日的月收入整数：

收入来源	申请人/患者	配偶/同居伴侣
薪水	$	$
社会保障支付金	$	$
失业补偿金	$	$
残障支付金	$	$
劳工赔偿金	$	$
赡养费/儿童抚养费	$	$
股息、利息、租赁收入	$	$
其他	$	$

请提供能证明所有所报收入的支票、薪资存根或月结单的备份件。

☐ **我允许康康保险代表与我联系，协助我申请政府资助健康保险。**

最佳联络时段： ☐ **上午** ☐ **下午** ☐ **晚上** ☐ **周末** ☐ **任何时候** ☐ **请勿联系我**

我谨此证明：所提供的信息和证明资料以及给出的回答均真实无误。对任何减少的或调整过的余额，如果本人未能支付，将使本人面临Northwell Health公司的正常收费和催账举措。

X _____ _____/_____/_____

申请人/患者签名（未成人孩子的家长/合法监护人）　日期

Northwell Health®

Financial Assistance Application Instructions

The Northwell Health Financial Assistance Program is designed to help patients who have received medically necessary services but are uninsured or have exhausted their benefits for a particular service. Eligibility for the program is based on current income and is available to individuals with household incomes that are less than those shown below:

Household / Family Size	Maximum Household Income (500% of 2022 of Federal Poverty Guidelines)
1	$67,950
2	$91,550
3	$115,150
4	$138,750
5	$162,350
6	$185,950
For each additional person, add	$23,600
* 2022 shown for illustrative purpose. Amounts updated annually as necessary.	

When completing an application for Financial Assistance please remember the following:

- An application is not complete until all Required Documentation is received. An incomplete application **will not** be reviewed and the normal billing cycle will continue.
- **Required Documentation** – attach copies of checks, pay stubs or statements that support any of the types of income that are reported on your financial assistance application. In addition, please provide copies of all bills or statements that you would like reviewed as part of your application. Note that we reserve the right to request additional documentation related to assets for patients with household incomes under 150% of the Federal Poverty Level.
- Once we receive your completed application, you can disregard any bills / statements until you receive written notification regarding the status of your financial assistance application.
- Applicants for financial assistance are expected to fully cooperate in applying for any government sponsored health insurance program (e.g., Medicaid, Child Health Plus, etc.) that Northwell Health believes you may be eligible for.
- Please mail your application to:

  Mather Hospital Northwell Health
  Financial Assistance Unit
  100!Highlands Blvd Box 9
  Port Jefferson, NY 11777

For more information please call 631-476-2801 Option 1

Northwell Health®

FINANCIAL ASSISTANCE APPLICATION

Applicant's Information:

_____ _____-_____-_____ _____/_____/_____ _____
Applicant's, Parent, Guardian Name | Social Security Number | DOB: Mo Day Year | Preferred Language

_____
Applicant's Home Address City State Zip Code

(_____) _____-_____ (_____) _____-_____ _____
Cell, Home, Work Phone Number | Cell, Home, Work Phone Number | Email Address

Patient's Information:

_____ _____-_____-_____ _____/_____/_____
Patient's Name | Social Security Number | DOB: Mo Day Year

Patient's Relationship to Applicant: ☐ Self ☐ Spouse/Partner ☐ Parent/Legal Guardian ☐ Child
☐ Other: _____
Please Specify

PLEASE STATE THE NORTHWELL HEALTH FACILITY THAT THE PATIENT HAS OUTSTANDING BILLS WITH:

_____

Approximate Date of Service: _____ Account Number(s): _____

Total Household Size: List the dependents who reside in the applicant's house for which the applicant takes financial responsibility. Check the appropriate box for each dependent.

Name	**Age**	**Relationship** Spouse/Partner	Parent	Child	Other
1. _____	_____	☐	☐	☐	☐
2. _____	_____	☐	☐	☐	☐
3. _____	_____	☐	☐	☐	☐
4. _____	_____	☐	☐	☐	☐
5. _____	_____	☐	☐	☐	☐

Total Gross Monthly Income for the last 30 days:

Sources of Income	Applicant/Patient	Spouse/Live-in Partner
Wages	$	$
Social Security Payment	$	$
Unemployment Compensation	$	$
Disability Payment	$	$
Workers Compensation	$	$
Alimony/Child Support	$	$
Dividends, Interests, Rental Income	$	$
Other	$	$

Please provide copies of checks, paystubs, or statements to support all reported income.

☐ **I allow a health insurance representative to contact me to assist me in applying for government sponsored health insurance.**

Best time to be reached: ☐ Morning ☐ Afternoon ☐ Evening ☐ Weekend ☐ Anytime ☐ Do NOT contact me

I certify that the information and documentation provided and that the answers given are truthful and accurate. My failure to pay any reduced or adjusted balance will subject me to the normal billing and collection practices of Northwell Health.

X _____ _____/_____/_____
Applicant/Patient Signature (Parent/Legal Guardian for minor child) Date