Northwell Health®

財務補助申請說明書
(Financial Assistance Application Instructions)

Northwell Health 財務補助計劃旨在資助那些獲得醫療必需服務但沒有保險或用完某一具體服務福利的患者。符合該計劃的資格是以當前收入狀況為基礎的，僅對家庭收入低於下列個人提供：

家人 / 家庭的人口數	最大家庭收入 （2023 年《聯邦貧困指南》的 500%）
1	$72,900
2	$98,600
3	$124,300
4	$150,000
5	$175,700
6	$1201,400
針對每一個額外的人口，增加	$25,700
* 顯示的 2023 年資料僅供說明之用。每年會根據需要更新金額。	

在填寫財務補助申請時請記住以下事項：

- 一份申請，在所有必需証明材料收到之前，將被視為未完成。未完成申**請不會**被審查，正常收費周期將持續下去。
- **必需証明材料** — 能証明您財務補助申請所報任何形式的收入的支票、薪資存根或月結單，請附上其備份件。此外，您想作為要審查的申請部分內容的所有賬單或月結單，請提供其備份件。請注意：對於其家庭收入低於聯邦貧困標准150%的患者，我們保留權利索要更多與資產有關的証明材料。
- 一旦我們收到您的完整申請，您可以不管任何賬單/月結單，直到您收到關於您財務補助申請狀況的書面通知。
- 要求財務補助申請人全面配合申請Northwell Health公司認為您符合資格的任何政府資助健康保險計劃（例如：Medicaid，Child Health Plus等）。
- 請將您的申請郵寄至： Mather Hospital Northwell Health
  Financial Assistance Unit
  100 Highland Blvd Box 9
  Port Jefferson, NY 11777

若需更多信息，請致電631-476-2801 Option 2

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財務補助申請
(FINANCIAL ASSISTANCE APPLICATION)

申請人信息：

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

申請人、家長、監護人的姓名　社會保障號碼　出生日期：月 日 年　喜用語言

_____

申請人家庭地址、城市、州、郵政編碼

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

手機、住宅、工作電話　手機、住宅、工作電話　電郵信箱

患者信息：

_____ _____-_____-_____ _____/_____/_____

患者正楷姓名　社會保障號碼　出生日期：月 日 年

患者與申請人關係：　☐ 本人　☐ 配偶/伴侶　☐ 家長/合法監護人　☐ 兒童

☐ 其他：_____

請注明

請聲明患者在哪個NORTHWELL HEALTH 診所有未付賬單：

_____

大致服務日期：_____　賬號：_____

整個家庭人口：列出申請人家中居住的、申請人對其有財務責任的被贍養人。勾選每個被贍養人的相關復選框。

		關係			
姓名	**年齡**	配偶/伴侶	家長	孩子	其他
1. _____	_____	☐	☐	☐	☐
2. _____	_____	☐	☐	☐	☐
3. _____	_____	☐	☐	☐	☐
4. _____	_____	☐	☐	☐	☐
5. _____	_____	☐	☐	☐	☐

最近30日的月收入整數：

收入來源	申請人/患者	配偶/同居伴侶
薪水	$	$
社會保障支付金	$	$
失業補償金	$	$
殘障支付金	$	$
勞工賠償金	$	$
贍養費/兒童撫養費	$	$
股息、利息、租賃收入	$	$
其他	$	$

請提供能証明所有所報收入的支票、薪資存根或月結單的備份件。

☐ **我允許康康保險代表與我聯繫，協助我申請政府資助健康保險。**

最佳聯絡時段： ☐ **上午** ☐ **下午** ☐ **晚上** ☐ **周末** ☐ **任何時候** ☐ **請勿聯繫我**

我謹此証明：所提供的信息和証明資料以及給出的回答均真實無誤。對任何減少的或調整過的余額，如果本人未能支付，將使本人面臨Northwell Health公司的正常收費和催賬舉措。

X _____ _____/_____/_____

申請人/患者簽名（未成人孩子的家長/合法監護人）　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 Highland Blvd Box 9
  Port Jefferson, NY 11777

For more information please call 631-476-2801 Option 2

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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