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 2023 of Federal Poverty Guidelines)
1	$72,900
2	$98,600
3	$124,300
4	$150,000
5	$175,700
6	$201,400
For each additional person, add	$25,700
* 2023 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
  100 Highlands Blvd
  Port Jefferson, NY 11777
  MATH-FinancialAssistance@northwell.edu

  For additional information please call (631)476-2801 Opt: 2

VD046 (3/23/22)

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

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