Northwell Health®

Enstriksyon pou fè aplikasyon pou asistans finansye
(Financial Assistance Application Instructions)

Pwogram asistans finansye Northwell Health la fèt yon fason pou l ede pasyan ki te resevwa sèvis ki medikalman nesesè men yo pa gen asirans oswa yo te epuize benefis yo pou yon sèvis an patikilye. Yo baze elijiblite pou pwogram nan sou revni aktyèl pasyan an epi pwogram nan disponib pou moun kote revni fanmi yo mwens pase sa ki endike anba a:

Moun ki nan kay la / gwosè fanmi an	Revni maksimòm moun ki nan kay la (500% direktiv sou nivo povrete federal pou 2023 an)
1	$72,900
2	$98,600
3	$124,300
4	$150,000
5	$175,700
6	$201,400
Pou chak moun siplemantè, ajoute	$25,700
* Yo montre ane 2023 an kòm egzanp. Yo mete montan yo ajou chak ane si sa nesesè.	

Lè w ap ranpli yon aplikasyon pou asistans finansye tanpri sonje sa ki site la a:

- Yon aplikasyon pa konplè pazavan nou resevwa tout dokiman ki obligatwa yo. Nou **pa pral** egzamine yon! aplikasyon ki pa konplè epi peryòd faktirasyon nòmal la pral kontinye.
- **Dokiman ki obligatwa –** atache kopi chèk, souch chèk oswa deklarasyon ki sipòte nenpòt nan tip revni ou rapòte! sou aplikasyon pou asistans finansye w la. Anplis de sa, tanpri ban nou kopi tout fakti oswa deklarasyon ki fè pati! aplikasyon w lan ou ta renmen nou egzamine. Note nou rezève dwa nou pou n mande w lòt dokiman ki gen rapò! ak byen pou pasyan ki gen revni ki pi ba pase 150% nivo povrete federal la.
- Yonfwa nou fin resevwa aplikasyon ou fin ranpli a, ou ka iyore nenpòt fakti / deklarasyon ou resevwa jiskaske ou! resevwa notis alekri konsènan estati aplikasyon pou asistans finansye w la.
- Nou atann pou moun ki fè aplikasyon pou asistans finansye koopere nèt lè y ap aplike pou nenpòt pwogram! asirans sante gouvènman an patwone (pa egzanp, Medicaid, Child Health Plus, eksetera) epi Northwell Health! kwè ou ka elijib pou jwenn.
- Tanpri voye aplikasyon w lan pa lapòs nan:

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

Pou plis enfòmasyon tanpri rele 631-476-2801 Option 2

Northwell Health®

APLIKASYON POU ASISTANS FINANSYE
(FINANCIAL ASSISTANCE APPLICATION)

Enfòmasyon kandida a:

_____ _____-_____-_____ _____/_____/_____ _____
Non kandida a, paran, gadyen | Nimewo sekirite sosyal | Dat nesans: Mwa Jou Ane | Lang prefere

_____
Adrès kay kandida a Vil Eta Kòd postal

(_____) _____-_____ (_____) _____-_____ _____
Nimewo telefòn selilè, lakay, travay | Nimewo telefòn selilè, lakay, travay | Adrès imèl

Enfòmsyon pasyan an:

_____ _____-_____-_____ _____/_____/_____
Non pasyan an | Nimewo sekirite sosyal | Dat nesans: Mwa Jou Ane

Relasyon pasyan an ak kandida a: ☐ Mwen menm ☐ Konjwen/patnè ☐ Paran/gadyen legal ☐ Pitit
☐ Lòt: _____
Tanpri presize

TANPRI METE ETABLISMAN NORTHWELL HEALTH PASYAN AN GENYEN FAKTI KI POKO PEYE:

_____
Dat sèvis apwoksimatif: _____ Nimewo kont (yo): _____

Gwosè total fanmi an: Site depandan ki abite nan kay kandida a epi ki sou responsablite finansye kandida a. Tyeke bwat ki apwopriye pou chak depandan.

		Relasyon			
Non	**Laj**	Konjwen/patnè	Paran	Pitit	Lòt
1. _____	_____	☐	☐	☐	☐
2. _____	_____	☐	☐	☐	☐
3. _____	_____	☐	☐	☐	☐
4. _____	_____	☐	☐	☐	☐
5. _____	_____	☐	☐	☐	☐

Revni mansyèl brit total pou 30 jou ki sot pase yo:

Sous revni	Kandida/pasyan	Konjwen/patnè domestik
Salè	$	$
Pèman sekirite sosyal	$	$
Konpansasyon pou chomaj	$	$
Pèman envalidite	$	$
Konpansasyon pou aksidan travay	$	$
Pansyon alimantè/pansyon alimantè pou timoun	$	$
Dividann, enterè, revni lokasyon	$	$
Lòt	$	$

Tanpri bay kopi chèk, souch chèk oswa deklarasyon ki sipòte tout revni ou rapòte yo.

☐ **Mwen pèmèt pou reprezantan asirans sante a kontakte m pou ede w aplike pou asirans sante gouvènman an patwone.**

Lè ki pi bon pou kontakte m: ☐ Maten ☐ Aprèmidi ☐ Aswè ☐ Wikenn ☐ Nenpòt lè ☐ PINGA kontakte m

Mwen sètifye enfòmasyon ak dokiman mwen bay yo ak respons mwen bay yo se laverite epi yo egzat. Si mwen pa peye nenpòt balans kòb ki redui oswa ki ajiste mwen pral sijè a faktirasyon nòmal ak pratik koleksyon Northwell Health ka fè.

X _____ _____/_____/_____
Siyati kandida/pasyan (Paran/gadyen legal pou timoun ki minè) | Dat

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 2

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