NASSAU HEALTH CARE CORPORATION
PATIENT FINANCIAL ASSISTANCE PROGRAM

APPLICATION FOR FINANCIAL ASSISTANCE

IF YOU ARE ELIGIBLE FOR PATIENT FINANCIAL ASSISTANCE, YOUR NASSAU HEALTH CARE CORPORATION BILL MIGHT BE SUBSTANTIALLY REDUCED DEPENDING UPON YOUR INCOME, OTHER RESOURCES AND FAMILY SIZE. YOU MAY BE ELIGIBLE FOR PATIENT FINANCIAL ASSISTANCE REGARDLESS OF WHETHER YOU ARE A U.S. CITIZEN. HOUSEHOLDS WITH INCOME AT OR BELOW 350% OF THE FEDERAL POVERTY GUIDELINES ARE ELIGIBLE FOR FINANCIAL ASSISTANCE.

BEFORE YOU CAN BECOME ELIGIBLE UNDER THIS PROGRAM, YOU MUST FIRST DEMONSTRATE THAT YOU ARE NOT ELIGIBLE FOR MEDICAID, MEDICARE, OTHER SIMILAR GOVERNMENT ENTITLEMENT PROGRAMS OR ANY PRIVATE HEALTH INSURANCE. IF YOUR FINANCIAL COUNSELOR BELIEVES THAT YOU MAY BE ELIGIBLE FOR MEDICAID, MEDICARE OR OTHER COVERAGE, YOU WILL BE ASKED TO APPLY FOR THAT COVERAGE BEFORE DETERMINING YOUR ELIGIBILITY FOR FINANCIAL ASSISTANCE.

ELIGIBILITY WILL BE BASED UPON WHERE YOU LIVE, YOUR HOUSEHOLD SIZE AND INCOME AND THE AVAILABILITY OF CERTAIN OTHER RESOURCES. FINANCIAL RESPONSIBILITY WILL BE DETERMINED BY USING A SLIDING FEE SCHEDULE WHERE THOSE MOST IN NEED WILL RECEIVE THEIR CARE AT THE LOWEST COST.

ONCE YOU HAVE SUBMITTED A COMPLETED APPLICATION (INCLUDING DOCUMENTATION) YOU MAY DISREGARD ANY BILLS YOU RECEIVE FROM NASSAU HEALTH CARE CORPORATION UNTIL SUCH TIME AS A DECISION IS MADE ON YOUR APPLICATION.

IT IS YOUR RESPONSIBILITY TO COMPLETE THIS APPLICATION AND RETURN IT, ALONG WITH ALL OF YOUR SUPPORTING DOCUMENTATION, WITHIN THIRTY (30) DAYS. IF YOU HAVE QUESTIONS OR REQUIRE ASSISTANCE, SPEAK CONTACT YOUR FINANCIAL COUNSELOR.
Application
Nassau Health Care Corporation
Patient Financial Assistance Program

PLEASE PRINT ALL RESPONSES AND SIGN ON BACK OF THIS PAGE

I. Date of Treatment/Discharge: ___________ ACCOUNT # ___________

Patient Name: ___________________________ Social Security # ___________

First         Middle         Last

Address: ____________________________________________

Street Number    City        State        Zip

Telephone Number: ___________________________

* * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * *

II. Members of Household (other than Applicant):

Names

__________________________

__________________________

__________________________

__________________________

__________________________

__________________________

__________________________

__________________________

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III. Employment Information:

Employer’s Name: ___________________________

Job Title: ___________________________ Salary $ ___________ weekly

Employer’s Address: ___________________________

Street Number    City        State        Zip

Employer’s Telephone Number: ___________________________

* * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * *

IV. Other Resources:

Bank: ___________________________ __Savings __Checking

Name

(OVER)

FINANCIAL ASSISTANCE APPLICATION 1/07
Account Number: ____________________________

Account Owner(s): ____________________________

Current Balance: $ ____________________________

Other: ____________________________  Savings  Checking

Name

Account Number: ____________________________

Account Owner(s): ____________________________

Current Balance: $ ____________________________

I certify that the information provided in this Application is truthful and accurate.

_______________________________  Date: ____________
Signature

For Hospital Use Only:

Name of Financial Counselor: ____________________________  Name Printed

Phone Number: ____________________________  Application #: ____________

Date Application Initiated: ____________________________

Date Completed Application Received: ____________________________

List Documents Reviewed:

Proof of Income: ____________________________  Name of Document Reviewed

Household Size: ____________________________  Name of Document Reviewed

Proof of Residence: ____________________________  Name of Document Reviewed

Assets: ____________________________  Name of Document Reviewed

Eligibility Determination: $ ____________________________  Amount to be Paid by Applicant

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