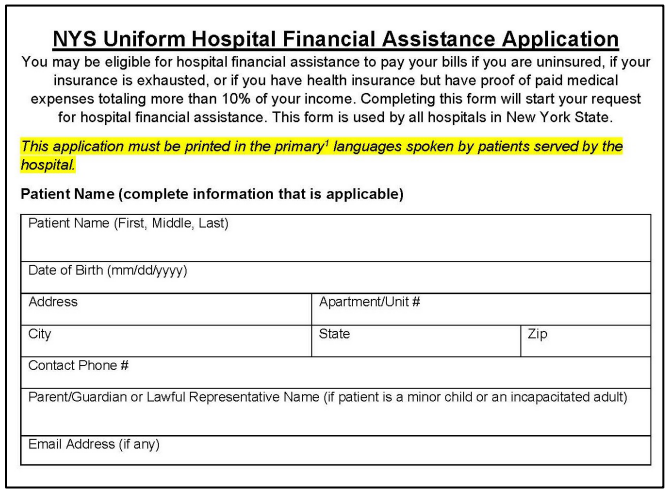
Tips for Completing the New York State Hospital Financial Assistance Application

All hospitals in New York State must use the same hospital financial assistance application. You only need to complete the first two pages.

Consumers applying for hospital financial assistance have rights:

- You have the right to ask the hospital to give you an application in your language. English and many translations can be found **here**.
- The hospital cannot ask about your immigration status or citizenship.
- You have the right to apply for financial assistance at any time and to have your application processed – even before you get a bill. Anyone who cannot pay their hospital bills should apply.
- The hospital must issue a decision in writing within 30 days of receiving a complete application and all supporting documents.
- The hospital cannot send your bill to a collector until you get a decision letter.
- If you disagree with the decision, you can appeal. The level of financial assistance you get and how to appeal must be in the decision letter.

Completing the Form:



NYS Uniform Hospital Financial Assistance Application

You may be eligible for hospital financial assistance to pay your bills if you are uninsured, if your insurance is exhausted, or if you have health insurance but have proof of paid medical expenses totaling more than 10% of your income. Completing this form will start your request for hospital financial assistance. This form is used by all hospitals in New York State.

This application must be printed in the primary[1] languages spoken by patients served by the hospital.

Patient Name (complete information that is applicable)

Patient Name (First, Middle, Last)		
Date of Birth (mm/dd/yyyy)		
Address	Apartment/Unit #	
City	State	Zip
Contact Phone #		
Parent/Guardian or Lawful Representative Name (if patient is a minor child or an incapacitated adult)		
Email Address (if any)		

Patient Name: The person whose name is on all the bills goes here. Immigration status is not considered for hospital financial assistance applications.

Note: If you are a parent or guardian filling out the form for someone else, write your name in the Parent/Guardian or Lawful Representative line at the bottom of this section.

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Community Health Advocates is a program of the Community Service Society of New York.

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Full Name	Relationship	Total Gross Income (Current)
	Self	

Family Information: Include only members of the patient's family who may be listed on the same tax return.

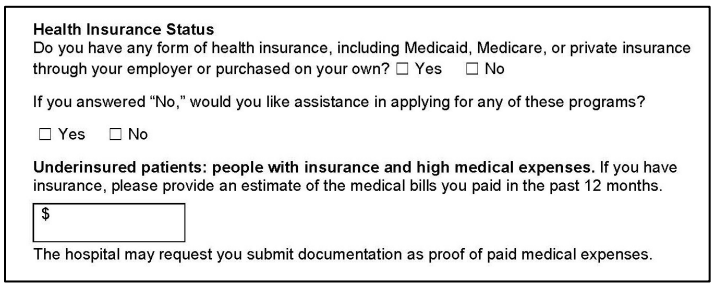
- If the patient is a child, parents/guardians and siblings should be listed.
- Seniors living with adult children can be included as part of the household on the application if they are claimed as dependents on the adult child's tax forms.
- Roommates do not count as part of household size.

Gross Income: Monthly or annual income is accepted. Ways to prove your gross income (before taxes are taken out) are on page 5 of the application. Common types of proof are: pay stubs, Social Security Award letters, or NYSOH eligibility determination letters. If you have no income it is OK to submit a signed letter **that says you currently have no income** (**see example "self-attestation" letter on page 4 of this document**).

Important!

- Hospitals may **not** ask for bank statements or tax returns.
  - You may provide a tax return if it is helpful for you (for example, you were employed last year and currently live on savings).

- If you currently have no income, hospitals may ask how you are meeting your monthly expenses (for example if you are living with family, living off savings, receiving help from family, etc.). Include this explanation in the letter you submit that says you currently have no income (**see example "self-attestation" letter on page 4 of this document**).
  - If you have other circumstances the hospital should know about when reviewing your application, include that information in your letter. For example, if you have other debt or expenses that make paying the hospital bill difficult.



Health Insurance Status
Do you have any form of health insurance, including Medicaid, Medicare, or private insurance through your employer or purchased on your own? ☐ Yes ☐ No

If you answered "No," would you like assistance in applying for any of these programs?

☐ Yes ☐ No

Underinsured patients: people with insurance and high medical expenses. If you have insurance, please provide an estimate of the medical bills you paid in the past 12 months.

$

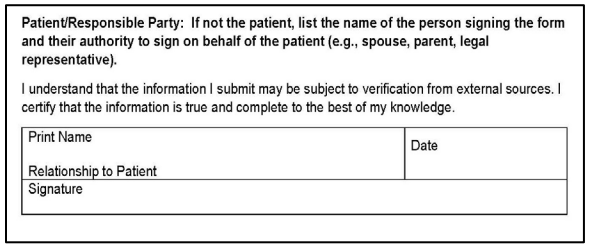
The hospital may request you submit documentation as proof of paid medical expenses.

Health Insurance Status: Answer with your current status. If you were uninsured on the date of service (but have insurance now), you can include that in your letter or write a note on the application. Ask the hospital to process the application as "uninsured" at time of service.

Underinsured patients: **Fill out this section if you have insurance and cannot afford your cost sharing or still have high bills.**

Provide your best estimate of the amount you've been charged for medical bills in the last 12 months — **these bills do not have to be paid.** This includes dental, vision, deductibles, co-pays, co-insurance, prescriptions, etc. (Insurance premiums should not be included.) This estimate should include health care costs for all household members listed on the application.

Sign and submit: The form or the hospital's website should tell you where (and how) to submit the application. You can also check your online portal account to see if you can fill out an application there.



Patient/Responsible Party: If not the patient, list the name of the person signing the form and their authority to sign on behalf of the patient (e.g., spouse, parent, legal representative).

I understand that the information I submit may be subject to verification from external sources. I certify that the information is true and complete to the best of my knowledge.

Print Name Relationship to Patient	Date
Signature	

If you need help submitting your application, call Community Health Advocates (888-614-5400, option 3). **Keep a copy of your application and all other documents you submit, including information on your income or any medical bills.**

REMEMBER: You have the right to apply for financial assistance and to have your application processed. Some hospitals offer assistance to consumers with incomes above what is required by law. When in doubt…apply! For more information, visit: Hospital Financial Assistance (HFA) Information for New Yorkers - Community Health Advocates.

Self-Attestation of No Income for NYS Hospital Financial Assistance

Complete this form only if you (or the patient, if you are filling this out on someone else's behalf) do not have any regular sources of income, like wages, Social Security, unemployment benefits, retirement income, cash assistance, etc. You should explain how you support yourself and your dependents.

Patient Name: _____

Address: _____

City, State, Zip: _____

Date of Birth: _____

My last job was in (MM/YY): _____

My last employer was: _____

Please explain below why you do not have regular income and how you meet your monthly expenses, including housing:

_____

By signing below, I certify that I have no other way to document the above information and that all of the above information is true and correct. I understand that this information will be used to determine my eligibility for hospital financial assistance. I also understand that hospital staff may verify the information on this form.

Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____