Phelps Hospital
Northwell Health℠

Date _____

Name _____

Account(s) _____

As part of our continuing effort to provide services to the uninsured and underinsured, Phelps Hospital offers financial assistance to those who qualify.

Attached you will find our Financial Assistance application. ***This application must be returned to us within 90 days from the date of this letter.*** Proof of income, resources and residency is required. Please refer to the enclosed document check- list as a reference.

Upon receipt of the completed application and documentation, your application will be reviewed and a decision will be sent to you in writing.

If you have any questions, please contact me at (914) 366-3133.

Sincerely,

Patient Accounting Department
Financial Counseling Services

Proof of income and resources must be provided for Charity Care consideration

PHELPS HOSPITAL
NORTHWELL HEALTH
FINANCIAL ASSISTANCE APPLICATION

Patient Name:_____ Date:_____

Account(s) #:_____

RESPONSIBLE PARTY:

Name: _____

Spouse's Name:_____

Address:_____Apt #:_____

City/State:_____ Zip Code:_____

Phone:_____ Cell:_____

Mailing Address (if different from above): _____

HOUSEHOLD INFORMATION

Total number of dependents in household including yourself: _____

Please indicate all sources of income below.

$ MONTHLY INCOME	**$ Patient**	**$ Spouse**	**$ Parent / $Guarantor**	**$ Other**	**Total**
Wages:					
Social Security Award Amount:					
Pension / Annuity:					
Unemployment Benefit:					
Rental Income:					
Child Support:					
Veteran's Benefit:					
Worker's Compensation Benefits:					
Other Income:					

QUALIFYING MONTHLY INCOME $_____

QUALIFYING HOUSEHOLD SIZE #_____

I certify that to the best of my knowledge, all answers on this form are true and complete.

Signature:_____ Date:_____

The hospital will provide a determination within 30 days of receipt of the application for financial assistance and supporting documentation. You may disregard billing statements while your application for financial assistance is being considered. You are not responsible for that bill while your application is being processed.

Financial Counselors are available to assist you with the application process, and can be reached at (914)366-3133.

PHELPS HOSPITAL
NORTHWELL HEALTH

FINANCIAL ASSISTANCE PROGRAM

Documentation Needed To Support Your Financial Assistance Application

Proof of Identify (bring at least ONE from the list below)

- ☐ Passport
- ☐ Permanent Resident Alien Card (Green Card)
- ☐ Birth Certificate for all members in the family including children under 21 years old
- ☐ Employment Authorization Card
- ☐ Driver License
- ☐ Photo ID for Spouse / Common-Law Partners

Proof of Address/Residency-Home Address (bring at least TWO from list below)

- ☐ Utility bill
- ☐ Cell phone bill
- ☐ Cable television bill
- ☐ Rent receipt, copy of lease, or mortgage papers
- ☐ Letter from person you reside with or letter from landlord (must be notarized)

Proof of Income (bring at least ONE from the list below)

- ☐ Last four weekly pay stubs or two biweekly pay stubs
- ☐ Letter from employer on company letterhead, signed and dated, stating gross monthly income (If no letterhead, bring a notarized letter from the employer, signed and dated stating gross monthly income)
- ☐ Award letter from social Security Administration / Pension /Annuity
- ☐ Last unemployment benefit check copy, stub or printout
- ☐ Letter of support (If you are being wholly supported by someone else, bring a notarized letter from that person which states that they are supporting the patient in the absence of income)
- ☐ If unemployed, explanation of support required (Please clarify in a letter how the patient is being supported (i.e. bank savings, etc.)
- ☐ Income from rental of property, room, etc.
- ☐ If applying for a child, please provide documentation of child support income
- ☐ V.A. Benefits or Worker's Compensation Income

Other

- ☐ Proof of school attendance

Patient Accounting Department
(914) 366-3133