North Shore LIJ North Shore-Long Island Jewish Health System

Financial Assistance Application Instructions

The North Shore-LIJ Health System 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 Federal Poverty Level)
1	$55,850
2	$75,650
3	$95,450
4	$115,250
5	$135,050
6	$154,850
For each additional person, add	$19,800

When completing an application for Financial Assistance please remember the following:

- You have 90 days from the date of service to apply for financial assistance and 20 days to complete the application and return it to us.

- 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** – please 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 us to review 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 your financial assistance application.

- Applicants for financial assistance will be expected to fully cooperate in applying for any public insurance program (e.g., Medicaid, Child Health Plus, etc) that NSLIJ believes you may be eligible for.

- Please mail your application to:

  North Shore LIJ Health System
  Financial Assistance Unit
  PO Box 9001
  Melville, NY 11747-9001

For more information please call 1.800-995-5727

Revised 3.2012

North Shore LIJ North Shore-Long Island Jewish Health System

FINANCIAL ASSISTANCE APPLICATION

Applicant's Information:

_____ _____-_____-_____ ____/____/____
Applicant's Name Social Security Number (Optional) DOB: Mth Day Year

_____ _____, _____ _____
Applicant's Home Address City State Zip Code

(____) _____-_____ (____) _____-_____ (____) _____-_____
Home Phone Number Cell phone Number Work Phone Number/Other

Patient's Information:

_____ _____-_____-_____ ____/____/____
Patient's Name Social Security Number (Optional) DOB: Mth Day Year

Patient's Relationship to Applicant:
___ Self ___Spouse/Partner ___Parent/Legal Guardian ___Child ___Other: _____
Please Specify

PLEASE CIRCLE THE NS-LIJHS FACILITY THAT THE PATIENT HAS OUTSTANDING BILLS WITH.

NORTH SHORE LIJ GLEN COVE PLAINVIEW FOREST HILLS FRANKLIN SOUTHSIDE

SYOSSET LENOX HILL

Approximate Date of Service: _____ Account Number(s): _____

Total Household Size: List the dependents who reside in the applicant's house for whom 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. _____	_____	☐	☐	☐	☐
6. _____	_____	☐	☐	☐	☐

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 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 the Health System.

X_____ _____/_____/_____
Applicant/Patient Signature Date
(Parent/Legal Guardian for minor child)

Mail Completed Application to: NSLIJ Financial Assistance Unit, P.O. Box 9001, Melville, NY 11747-9001