White Plains Hospital

RECV'D

FINANCIAL ASSISTANCE APPLICATION

If you think you may be eligible for Financial Assistance and wish to request it, please contact The Patient Accounts Department at (914) 681-1004.

PATIENT NAME_____ DOB_____

ADDRESS_____CITY_____STATE_____ZIP _____

PHONE NUMBER_____ SOCIAL SECURITY #_____

MARITAL STATUS_____ FAMILY SIZE_____

SPOUSE NAME _____DOB_____ SOCIAL SECURITY #_____

EMPLOYER (PATIENT) _____

EMPLOYER (SPOUSE) _____

*IF PATIENT IS A MINOR PLEASE INCLUDE EMPLOYMENT INFORMATION OF PARENT (S)

DOES ANYONE ELSE CLAIM YOU ON THEIR INCOME TAX: ____YES ____NO

LIST HOUSEHOLD MEMBERS / DEPENDENTS

NAME	RELATION TO PT	DOB

DEFINITION INCOME

	Patient	Spouse	Mother	Father
Wages				
Social Security payment				
Unemployment compensation				
Disability				
Workers Compensation				
Alimony/Child Support				
Rental/boarder Income				
Pension/Retirement				
Other				

Individual Written Notice to All Patients
Notice of Availability of Financial Assistance

In recognition that all patients who seek health care from White Plains Hospital may not have the financial resources or insurance coverage to afford care, the Hospital will make available a reasonable amount of uncompensated services to persons meeting the eligibility requirements. Patient eligibility for financial assistance is determined by measuring family income against the Federal Income Poverty Guidelines established by the Department of Health and Human Services.

GIVEN/SENT

DETERMINATION FOR FINANCIAL ASSISTANCE

DATE OF SERVICE_____

ACCOUNT NUMBER(S)_____

I HEREBY CERTIFY THAT THE ABOVE INFORMATION FURNISHED TO WHITE PLAINS HOSPITAL IS TRUE AND CORRECT. I AUTHORIZE WHITE PLAINS HOSPITAL TO VERIFY ANY INFORMATION GIVEN ABOVE, IF DEEMED NECESSARY.

Signature of Applicant/Authorized representative

_____

Date:_____

Witness:_____ Date:_____

▼ Below, For hospital use only ▼

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PATIENT NOTIFICATION OF DETERMINATION OF FINANCIAL ASSISTANCE FUNDS:

DENIAL REASON:

_____

_____

_____

IF APPEAL, APPEAL NOTICE
DATE_____RESOLUTION_____

INCOME: + _____ **ASSETS: + _____** **TOTAL: _____** **FAMILY SIZE:____**	**FINANCIAL ASSISTANCE APPROVAL RATE:** **100% 75% 50% 25%** **COPAY COVERAGE NOMINAL FEES**

White Plains Hospital

- ☐ Valid Photo identification
- ☐ Current pay stubs (last 6) **or** Statement from employer (Name, address, phone number)
- ☐ Proof of Residency (i.e. Utility bills, Con Ed, Telephone)
- ☐ 3 months of bank statements of all your accounts
- ☐ Social Security Income Letter if applicable