NYACK HOSPITAL
Patient Financial Services
160 North Midland Avenue
Nyack, NY 10960

Dear Patient;

Enclosed please find attached an Application for Charity Care/Financial Aid. You may apply for Charity Care/Financial Aid at any time during the billing and collection process. Please complete the application and attach all supporting documents and return it to the address shown above.

If your application is incomplete, we will not be able to process it.

If you need any further assistance or have any questions regarding this package of materials, please contact our Financial Counseling Unit at **(845)-348-2323**.

To further assist us in processing your application for Charity Care/Financial Aid, see the following examples you might choose to include with your application in order to document your income:

- Pay stubs
- Letter from employer, if applicable.
- Tax Form 1040
- Any other information that may validate your income

If you are under twenty-one (21) years of age, AND/OR you are a dependent of your parent(s)/guardian(s), then your parent or guardian must fill out the eligibility application form entitled **APPLICATION FOR CHARITY CARE/FINANCIAL AID** and provide the necessary supporting documents.

A telephone number where you can be reached MUST BE PROVIDED, as well as complete addresses, including apartment numbers and letters.

A note describing your situation as well as copies of any of the applicable documents listed above or other supporting documentation which you might choose to submit would be helpful in determining your or your child's eligibility.

If you are a student, please provide documentation of your student status.

NOTICE TO PATIENTS:
IF YOU SUBMIT A COMPLETED APPLICATION INCLUDING INFORMATION OR DOCUMENTATION NECESSARY TO DETERMINE ELIGIBILITY UNDER THE HOSPITAL'S CHARITY CARE/FINANCIAL AID POLICY, YOU MAY DISREGARD ANY HOSPITAL BILL UNTIL WE HAVE MADE A DECISION ON YOUR APPLICATION

Applications with supporting documentation are to be mailed to:

NYACK HOSPITAL
Patient Financial Aid Services
Financial Counseling Unit
160 North Midland Avenue
Nyack, NY 10960

Nyack Hospital

NYACK HOSPITAL
APPLICATION FOR CHARITY CARE/FINANCIAL AID

Patient's Name _____ Date of Birth: _____
Last **First** **Middle Initial**

Address: _____
Number & Street, Apt. # **City** **State** **Zip**

Telephone: (_____) _____ Occupation: _____ Employer:_____

Employer Address: _____ Employer Tel # _____

Income – List combined income for yourself, spouse, and all other household member from:

Type of Income	Total Last 3 Months	Total Last 12 Months
Wages		
Self-employment Earnings		
Public Assistance		
Social Security		
Unemployment/Worker's Compensation		
Alimony		
Child Support		
Pensions		
Income from Dividends		
Resources (bank accounts, investments, loans, etc.)		
Total		

The hospital requests that you submit documentation to substantiate the income you entered above. Examples of documentation might include pay stub, letter from employer if applicable, Form 1040 etc.

Family Size – Family members living in your household:

Name	Age	Relationship

THIS APPLICATION MAY BE SUBMITTED TO THE HOSPITAL AT ANY TIME DURING THE BILLING AND COLLECTION PROCESS

Nyack Hospital

NYACK HOSPITAL
APPLICATION FOR CHARITY CARE/FINANCIAL AID

Once you have submitted a completed application and supporting documentation to the hospital at the address below, you may disregard any bills until the hospital has rendered a written decision on you application.

To submit this application for charity care, please read the following statement and sign where indicated below.

I HEREBY REQUEST THAT NYACK HOSPITAL MAKE A WRITTEN DETERMINATION OF MY ELIGIBILITY FOR CHARITY CARE/FINANCIAL AID.

I UNDERSTAND THAT THE INFORMATION WHICH I SUBMIT CONCERNING MY ANNUAL INCOME AND FAMILY SIZE IS SUBJECT TO VERIFICATION BY THE HOSPITAL. I ALSO UNDERSTAND THAT IF THE INFORMATION WHICH I SUBMIT IS DETERMINED TO BE FALSE, SUCH DETERMINATION WILL RESULT IN A DENIAL OF CHARITY CARE/FINANCIAL AID THAT I MAY BE LIABLE FOR CHARGES FOR SERVICES PROVIDED.

I AFFIRM THAT THE INFORMATION ABOVE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. FURTHER, I HEREBY GIVE MY PERMISSION TO NYACK HOSPITAL TO VERIFY ANY INFORMATION PERTINENT TO THIS APPLICATION.

Signature of Applicant _____ Date _____

Account # _____

Completed Application to be sent to:

NYACK HOSPITAL
Patient Financial Services
Financial Counseling Unit
160 North Midland Avenue
Nyack, NY 10960