Montefiore | Nyack

MR# _____

New York Hospital Care Assistance Program
DETERMINATION OF APPLICATION FOR PARTICIPATION

SECTION I – APPLICANT INFORMATION

1. PATIENT NAME	DOB	2. FAMILY SIZE
3. DATE OF SERVICE	4. DATE OF DETERMINATION	5. DATE OF EXPIRATION
6. INCOME COMPUTATION [ ] 12 Months [ ] 13 Weeks x 4 [ ] 3 Months [ ] 1 Month x 12		7. TOTAL INCOME

SECTION II – MEDICAID DETERMINATION

8. WAS REFERRAL MADE FOR PUBLIC ASSISTANCE

[ ] Yes [ ] No Explain: _____

SECTION III - DETERMINATION

[ ] Your request for New York hospital assistance has been approved. Your financial is _____ of the Hospital bill for services beginning on _____. The hospital may provide assistance of _____ of the Hospital charges for any future hospital services for a period of _____ months for the initial date of service.

[ ] Your request for New York hospital assistance has been denied because you do not meet the eligibility requirements.

Specific reasons for ineligibility are as follows:
[ ] Documentation of income not provided.
[ ] Income exceeds eligibility
[ ] Patient referred to Medicaid.
[ ] Failure to provide Medicaid denial.
[ ] Other:
_____

DOES NOT COVER
Cosmetic Surgery
Prescription Drugs
Doctor's Fee
Therapy Outside the Hospital
Anesthesia

*Applicants found ineligible based on the fact that specific information was not provided should direct this information to the Hospital:

Applicants who have questions about the program may contact

Montefiore Nyack Hospital
160 North Midland Avenue
Nyack, NY 10960
Contact Number: (845) 348-2323

NAME OF EVALUATOR	TITLE
SIGNATURE	DATE

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MONTEFIORE NYACK HOSPITAL
APPLICATION FOR CHARITY CARE/FINANCIAL AID

PROOF OF INDENTIFICATION AND PROOF OF INCOME MUST ACCOMPANY THIS APPLICATION
SEND COPIES OF ALL REQUESTED DOCUMENTS. DO NOT SEND ORIGINAL DOCUMENTS AS THEY WILL NOT BE RETURNED.

SECTION I – PERSONAL INFORMATION

1. PATIENT NAME _____ _____ _____ (Last) (First) (MI)		2. DATE OF BIRTH _____ _____ _____ Month Day Year
3. DATE OF APPLICATION _____ _____ _____ Month Day Year	4. INITIAL DATE OF SERVICE _____ _____ _____ Month Day Year	5. REQUESTED DATE OF SERVICE _____ _____ _____ Month Day Year
6. STREET ADDRESS OF PATIENT		7. TELEPHONE NUMBER
8. CITY, STATE, ZIP CODE		9. FAMILY SIZE
10. OCCUPATION		11. EMPLOYER
12. EMPLOYER ADDRESS		13. EMPLOYER TELEPHONE #
14. NAME OF GUARANTOR (IF OTHER THEN PATIENT)		

SECTION II – FAMILY SIZE

15. FAMILY SIZE

NAME	AGE	RELATIONSHIP

***Family size includes self, spouse and any minor children. A pregnant woman is counted as two family members.**

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APPLICATION FOR PARTICIPATION (CONTINUED)

SECTION III – INCOME CRITERIA

Proof of household income determines eligibility for hospital care assistance must accompany this application.
Income is based on the calculation of either twelve months, three months or one month of income prior to the date of service.

Patient/Family Gross Income equals the lesser of the following:

LAST 12 MONTHS	or	LAST 3 MONTHS X 4	or	LAST 1 MONTH X 12

16. SOURCES OF INCOME

			WEEKLY	MONTHLY	YEARLY
A.	Salary/Wages Before Deductions	_____	[ ]	[ ]	[ ]
B.	Public Assistance	_____	[ ]	[ ]	[ ]
C.	Social Security Benefits	_____	[ ]	[ ]	[ ]
D.	Unemployment & Workmen's Compensation	_____	[ ]	[ ]	[ ]
E.	Veteran's Benefits	_____	[ ]	[ ]	[ ]
F.	Alimony/Child Support	_____	[ ]	[ ]	[ ]
G.	Other Monetary Support	_____	[ ]	[ ]	[ ]
H.	Pension Payments	_____	[ ]	[ ]	[ ]
I.	Dividends/Interest	_____	[ ]	[ ]	[ ]
J.	Rental Income	_____	[ ]	[ ]	[ ]
K.	Net Business Income (self employed/ verified by independent sources)	_____	[ ]	[ ]	[ ]
L.	Other (strike benefits, training stipends military family allotment, income from estates and trusts)	_____	[ ]	[ ]	[ ]
M.	Total	_____	[ ]	[ ]	[ ]

SECTION IV – CERTIFICATION BY APPLICANT

I understand that the information which I submit is subject to verification by the appropriate health care facility and the Federal or State Governments willful misrepresentation of these facts will me liable for all hospital charges and subject to civil penalties.

If so requested by the health care facility, I will apply for governmental or private medical assistance for payment of the hospital bill.

I certify that the above information regarding my family size and income is true and correct.

I understand that it is my responsibility to advise the hospital of any changes in status to my income.

17. SIGNATURE OF PATIENT OR GUARANTOR	18. DATE