



Maimonides

MEDICAL CENTER

4802 Tenth Avenue, Brooklyn, NY 11219

FINANCIAL ASSISTANCE APPLICATION

PROOF OF IDENTIFICATION, PROOF OF INCOME AND PROOF OF ASSETS 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
M.I.
2. Social Security Number: _____ -- _____ -- _____
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. City, State & Zip Code: _____
8. Telephone Number: _____
9. Family Size* (Number): _____
10. U.S. Citizenship: Yes No Pending Application
11. Proof of Identification: Citizenship papers, Passport, Birth Certificate, Drivers License _____
12. Proof of Residence: (Utility bills, Recent rent receipts) _____

SECTION II – Assets Criteria

When determining eligibility for hospital care assistance, an adult's assets includes his or her spouse's assets; a minor child's assets includes the assets of his or her parent(s) and/or legal guardian(s) with whom the child resides.

12. Individual's Assets: _____
13. Spouse, Parent(s) or Legal Guardian's(s) Assets (if applicable): _____
14. Assets Include:
 - A. Cash _____
 - B. Savings Accounts _____
 - C. Checking Accounts _____
 - D. Certificates of Deposits _____
 - E. Equity in Real Estate (other than primary residence) _____
 - F. Other Assets (Treasury Bills, negotiable paper, Corporate stocks and bonds) _____
 - G. Total _____

* Family size includes self, spouse residing with patient, and any dependents of patient or patient's spouse. A pregnant woman is counted as two family members. For patients who are minors, family size includes the minor, parents residing with the patient and dependents of such parents.

SECTION III –Income Criteria

When determining eligibility for hospital care assistance, an adult’s income includes his or her spouse’s income; a minor child’s income includes the income of his or her parent(s) and/or legal guardian(s) with whom the child resides.

PROOF OF INCOME MUST ACCOMPANY THIS APPLICATION

Income is based on the calculation of last four weeks earnings prior to the date of service.

15. Sources of Income:

- A. Salary / Wage Before Deductions (Last four weeks of pay stubs) _____
- B. Public Assistance _____
- C. Social Security Benefits _____
- D. Unemployment _____
- E. Veteran’s Benefit _____
- F. Alimony / Child Support _____
- G. Other Monetary Support _____
- H. Pension Payment _____
- I. Insurance or Annuity Payments _____
- J. Dividends / Interest _____
- K. Rental Income _____
- L. Net Business Income (self-employed / Verified by independent source) _____
- M. Other (strike benefits, training stipends, Military family allotments, income from Estates and trusts) _____

- N. Total _____

SECTION IV – Certification By Applicant

I understand that the information which I submit is subject to verification by appropriate health care facility. Willfull misrepresentation of these facts will make me liable for all hospital charges.

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, income, and assets is true and correct.

I understand that it is my responsibility to advise the hospital of any change in status in regards to my income or assets.

16. Signature of Patient or Legal Representative: _____

17. Date: ____/____/____
MONTH DAY YEAR

Upon submission of a completed application, including any information or documentation needed to determine eligibility, please disregard any bills until Maimonides has made a decision about whether to approve or deny the application.