Northwell Health®

纽约州统一医院经济援助申请表
(NYS UNIFORM HOSPITAL FINANCIAL ASSISTANCE APPLICATION)

如果您未投保、保险额度已用尽，或虽有健康保险但能证明已支付的医疗费用总额超过收入的 10%，那么您可能有资格获得医院经济援助以支付账单。填写此表即可开始申请医院经济援助。此表适用于纽约州所有医院。

此申请表必须以医院服务对象使用的主要[1]语言印制。

患者姓名（请填写适用的全部信息）

患者姓名（名字、中间名、姓氏）		
出生日期（年/月/日）		
地址	公寓/单元号	
城市	州	邮编
联系电话		
父母/监护人或法定代表人姓名（适用于未成年患者或无行为能力成年患者）		
电子邮箱（如有）		

家庭信息：
请在下方列出您家庭的所有成员。您的家庭成员包括您本人、配偶或同居伴侣，以及所有子女或其他受抚养人。例如，这包括所有列在同一纳税申报表上的人员。

总收入是指税**前**收入。

总收入可包括工作收入（工资、薪金、小费、自雇收入）、非劳动收入（社会保障金、残疾补助和失业救济金）、捐助（来自家人或朋友的资金）以及其他收入来源（临时援助和补充保障收入）。

[1] “主要语言”包括每年至少在 5% 的患者就诊中使用的任何语言，或主要医院服务区域内超过 1% 人口使用的任何语言。该数据基于美国人口普查局提供的人口统计信息计算得出，并结合学校系统的数据。

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纽约州统一医院经济援助申请表
(NYS UNIFORM HOSPITAL FINANCIAL ASSISTANCE APPLICATION)

全名	与患者关系	当前总收入
	本人	

医院可能会要求您提供收入证明文件，如工资单、雇主证明信（如适用）或 1040 表格。

健康保险状况
您是否有任何形式的健康保险？包括 Medicaid、Medicare，
或通过雇主提供或自行购买的私人保险？ ☐ 是 ☐ 否

如果您回答“否”，您是否需要协助申请这些保险项目？ ☐ 是 ☐ 否

保险不足患者：指有保险但医疗费用仍然高昂的人。
如果您有保险，请估算您在过去 12 个月内支付的医疗费用。

$

医院可能会要求您提供已支付医疗费用的证明文件。

患者/责任人：如非患者本人，请填写表格签署人的姓名及其代表患者签字的授权（如配偶、父母、法定代表人）。

本人明白，本人提交的信息可能会经由外部来源核实。本人保证，据本人所知，此信息真实完整。

患者/代理人/亲属/监护人（签字） (Patient/Agent/Relative/Guardian (Signature))	日期 (Date)	时间 (Time)	正楷书写姓名 (Print Name)

如果签字者不是患者本人，则说明与患者的关系
(Relationship if other than patient)

最低资格标准和指导原则
(MINIMUM ELIGIBILITY AND GUIDELINES)

申请时间安排、患者权利和保密性

- 您可以在催收过程的任何阶段申请经济援助。
- 在您收到经济援助申请结果之前，无需向医院支付任何款项。在您的申请处理期间，医院不得将账户转交给催收机构。
- 如果您的经济援助申请被拒绝，您有权提出上诉。您收到的医院通知中将说明上诉方式。您可能有权对经济援助金额提出上诉。医院将在其决定函中说明上诉方式。
- 医院在您收到第一张账单后至少 180 天内不得将未付账单转交给催收机构。
- 对于收入低于联邦贫困线 400% 的患者，医院不得采取法律行动（包括提起诉讼）来追回未付的医疗费用。贫困线标准可在此网址查询：https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines
- 此申请中提供的所有信息仅供医院用于确定您是否有资格获得经济援助，并将在法律允许的范围内予以保密。
- 医院不得因您有未结清的医疗账单而拒绝为您提供必要的医疗服务。
- 如果您在填写申请时需要帮助，**请联系 Northwell Health 的经济援助办公室，电话：(800) 995-5727。**
- 您可通过以下方式提交申请：拨打上述电话号码与代表联系、在线访问 https://www.northwell.edu/assistance 或邮寄至：Northwell Health Financial Assistance Unit，P.O. BOX 9001，Melville，NY 11747。
- 如果您需要关于此申请的进一步帮助或就决定提出上诉的协助，可以联系社区健康倡导者，电话：888-614-5400。

资格

医院可自行决定为收入水平高于以下规定的患者提供付款折扣，和（或）为符合条件的患者提供比《公共卫生法》要求更高的折扣，这不受任何限制。此外，移民身份不得作为确定经济援助资格的标准。

以下人员符合申请资格：

- 无健康保险的低收入个人；或
- 保险不足的个人（过去十二个月累计的自付医疗费用超过其年总收入的百分之十）；或
- 已用尽健康保险福利，并能证明无力支付全额费用的个人；或
- 经医院酌情决定，无力支付共付额和（或）自付额的个人可申请减免或折扣付款。

收入不超过联邦贫困线 400% 的个人有资格获得经济援助。

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最低资格标准和指导原则
(MINIMUM ELIGIBILITY AND GUIDELINES)

2025 年联邦贫困线标准			
家庭人口	**200%**	**300%**	**400%**
1 人	$ 31,300	$ 46,950	$ 62,600
2 人	$ 42,300	$ 63,450	$ 84,600
3 人	$ 53,300	$ 79,950	$ 106,600
4 人	$ 64,300	$ 96,450	$ 128,600
5 人	$ 75,300	$ 112,950	$ 150,600
6 人	$ 86,300	$ 129,450	$ 172,600
7 人	$ 97,300	$ 145,950	$ 194,600

每年更新，详见：https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines

最低折扣标准

如果您符合经济援助资格，您的费用将根据您的收入按以下浮动比例减免：

收入水平	**付款**
低于联邦贫困线 200%	免除全部费用
联邦贫困线 200% - 300%	无保险患者：浮动比例最高为 Medicaid 支付同等服务费用的 10%。 保险不足患者：最高为该患者保险费用分摊额的 10%。
联邦贫困线 301% - 400%	无保险患者：浮动比例最高为 Medicaid 支付同等服务费用的 20%。 保险不足患者：最高为该患者保险费用分摊额的 20%。

医院可自行决定为符合条件的患者提供更高折扣，和（或）为收入水平较高的患者提供付款折扣。

分期付款方案

无法一次性支付减免后费用的患者可选择分期付款方案。每月付款额不得超过您月总收入的 5%，且未付余额的利息（如有）不得超过 2%。

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家庭收入证明要求
(REQUEST FOR PROOF OF HOUSEHOLD INCOME)

请提供患者本人、配偶和所有受抚养人（如子女）的收入信息。例如，在计算家庭收入时，应包括同一纳税申报表上的所有人员（纳税人、配偶和税务受抚养人）。

以下是可用于证明收入的文件清单。您无需提供所有列出的文件。如果您没有收入，可以提供无家庭收入声明。

您也可以提供纽约州健康保险交易市场 (NY State of Health Marketplace) 的资格认定页面。如果您能提供此文件，则无需向医院提供下列其他收入证明。

家庭收入来源：	月收入金额：	申请人可提供的证明文件：
工资	$	请提供以下之一：工资单、带公司抬头的雇主证明信（需签名并注明日期），或最近提交的所得税申报表。
社会保障金	$	福利授款函或证明副本、美国社会保障局的信函或年度福利通知书。如需申请社会保障福利通知书副本，请拨打 1-800-772-1213 或访问 www.ssa.gov。
失业补助金	$	福利授款函或证明副本、纽约州劳工部的月度福利报表、直接付款卡副本及打印件、纽约州劳工部的信函，或从纽约州劳工部网站 (www.labor.state.ny.us) 打印的受益人账户信息。
残疾补助金	$	福利授款函或证明副本、社会保障局的信函或年度福利通知书副本。如需申请福利通知书副本，请拨打 1-800-772-1213 或访问 www.ssa.gov。
工伤赔偿金	$	福利授款函或工资支票存根副本。
赡养费或子女抚养费	$	法院判决书副本，或最近 3 个月的已兑现支票或收据。
股息或利息收入	$	季度股息报表或最近 1 个月的报表。
其他	$	说明非工资收入金额的证明信（如适用），例如租金收入、零工收入等。
无收入	$0	经签署的无收入声明。

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NYS UNIFORM HOSPITAL FINANCIAL ASSISTANCE APPLICATION

You may be eligible for hospital financial assistance to pay your bills if you are uninsured, if your insurance is exhausted, or if you have health insurance but have proof of paid medical expenses totaling more than 10% of your income. Completing this form will start your request for hospital financial assistance. This form is used by all hospitals in New York State.

This application must be printed in the primary[1] languages spoken by patients served by the hospital.

Patient Name (complete information that is applicable)

Patient Name (First, Middle, Last)		
Date of Birth (mm/dd/yyyy)		
Address	Apartment/Unit #	
City	State	Zip
Contact Phone #		
Parent/Guardian or Lawful Representative Name (if patient is a minor child or an incapacitated adult)		
Email Address (if any)		

Family Information:
Please list below all family members in your household. Your household includes yourself, your spouse or domestic partner, and any children or other dependents. For example, this would include everyone listed on the same tax return.

Gross income means your income **before** taxes are deducted.

Gross income can consist of work earnings (wages, salaries, tips, earnings from self- employment), unearned income (social security, disability, and unemployment benefits), contributions (funds from family or friends), and other sources of income (temporary assistance and supplemental security income).

[1] "Primary languages" includes any language that is used to communicate in at least 5% of patient visits per year, or any language spoken by more than 1% of the primary hospital service area population, as calculated using demographic information available from the United States Bureau of the Census, supplemented by data from school systems.

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NYS UNIFORM HOSPITAL FINANCIAL ASSISTANCE APPLICATION

Full Name	Relationship	Total Gross Income (Current)
	Self	

The hospital may request you submit documentation as proof of income; examples of documentation might include a pay stub, a letter from your employer if applicable, or Form 1040.

Health Insurance Status

Do you have any form of health insurance, including Medicaid, Medicare, or private insurance through your employer or purchased on your own? ☐ Yes ☐ No

If you answered "No," would you like assistance in applying for any of these programs? ☐ Yes ☐ No

Underinsured patients: people with insurance and high medical expenses.

If you have insurance, please provide an estimate of the medical bills you paid in the past 12 months.

$

The hospital may request you submit documentation as proof of paid medical expenses.

Patient/Responsible Party: If not the patient, list the name of the person signing the form and their authority to sign on behalf of the patient (e.g., spouse, parent, legal representative).

I understand that the information I submit may be subject to verification from external sources. I certify that the information is true and complete to the best of my knowledge.

_____ _____ _____ _____

Patient/Agent/Relative/Guardian* (Signature) Date Time Print Name

_____

Relationship if other than patient

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MINIMUM ELIGIBILITY AND GUIDELINES

Application Timeline, Patient Rights, and Confidentiality

- You can apply for financial assistance at any point during the collection process.
- You do not have to make any payment to this hospital until you receive a decision on your application for financial assistance. Hospitals may not forward accounts to collection while your application is pending.
- If you are denied financial assistance, you have the right to appeal. Information on how to do so will be included in the hospital's notice you receive. You may have the right to appeal the amount of your financial assistance. The hospital will include information about how to appeal in their decision letter.
- Hospitals cannot send unpaid bills to a collection agency for at least 180 days after your first bill.
- Hospitals are prohibited from taking legal action, including filing lawsuits, to recover unpaid medical bills for patients below 400% of the federal poverty level. Poverty guidelines can be found here: https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines
- Any information provided in this application will only be used by the hospital to determine your eligibility for financial assistance and will remain confidential to the extent permitted by law.
- A hospital cannot deny you medically necessary services because you have an outstanding medical bill.
- If you need assistance with this application, **please contact Northwell Health's Financial Assistance Office at (800) 995-5727.**
- Please submit your application by speaking to a representative at the above phone number, online at https://www.northwell.edu/assistance, or by mail at Northwell Health Financial Assistance Unit, P.O. BOX 9001, Melville, NY 11747
- If you need additional assistance with this application or help appealing a decision, you can reach out to Community Health Advocates: 888-614-5400.

Eligibility

Nothing limits a hospital's ability to establish patient eligibility for payment discounts at income levels higher than those specified below and/or to provide greater payment discounts for eligible patients than those required by Public Health Law. Additionally, immigration status shall not be an eligibility criterion for the purpose of determining financial assistance.

The following individuals are eligible:

- Low-income individuals without health insurance; or
- underinsured individuals (out-of-pocket medical costs accumulated in the past twelve months that amount to more than ten percent of such individual's gross annual income); or
- those who have exhausted their health insurance benefits, and who can demonstrate an inability to pay full charges; or
- at the hospital's discretion, individuals who can demonstrate an inability to pay their co- pay and/or deductible can request a reduced or discounted payment.

Individuals up to 400% of the federal poverty level are eligible for financial assistance.

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MINIMUM ELIGIBILITY AND GUIDELINES

Federal Poverty Levels (2025)			
Household Size	**200%**	**300%**	**400%**
1 Person	$ 31,300	$ 46,950	$ 62,600
2 Persons	$ 42,300	$ 63,450	$ 84,600
3 Persons	$ 53,300	$ 79,950	$ 106,600
4 Persons	$ 64,300	$ 96,450	$ 128,600
5 Persons	$ 75,300	$ 112,950	$ 150,600
6 Persons	$ 86,300	$ 129,450	$ 172,600
7 Persons	$ 97,300	$ 145,950	$ 194,600

Updated annually: https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines

Minimum Discount Rates

If you qualify for financial assistance, your charges will be reduced according to your income on a sliding fee scale as follows:

Income Level	**Payment**
Below 200% FPL	Waive all charges
200% - 300% FPL	Uninsured patients: Sliding scale up to 10% of the amount that would have been paid for the service(s) by Medicaid. Underinsured patients: Up to a maximum of 10% of the amount that would have been paid pursuant to such patient's insurance cost sharing.
301% - 400% FPL	Uninsured patients: Sliding scale up to 20% of the amount that would have been paid for the service(s) by Medicaid. Underinsured patients: Up to a maximum of 20% of the amount that would have been paid pursuant to such patient's insurance cost sharing.

Hospitals may choose to provide greater discounts for eligible patients and/or offer payment discounts for patients at higher income levels.

Installment Plans

Installment plans are available to patients who are unable to pay the reduced rate all at one time. Monthly payments cannot exceed 5% of your gross monthly income and the rate of interest charged to the patient on the unpaid balance, if any, shall not exceed 2%.

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REQUEST FOR PROOF OF HOUSEHOLD INCOME

Please include the income information for the patient, their spouse, and any dependents (such as children). For example, this would include everyone on the same tax return (tax filer, spouse, and tax dependents) in the calculation of household income.

The following is a list of documents you can use to prove your income. You do not have to provide all these documents. You can also provide a statement of no household income if you have no income.

You may also provide the Eligibility determination page from the NY State of Health Marketplace. If you have this document, you do not have to provide any other income information listed below to the hospital.

If Household Receives:	Amount per Month:	Applicant May Provide:
Wages	$	Please provide one Paycheck Stub, or Letter from Employer on company letterhead, signed and dated, or most recently filed income tax return.
Social Security Payment	$	Copy of award letter/certificate, or correspondence from the U.S. Social Security Administration, or annual benefit letter. To request a copy of your Social Security benefit letter, call 1-800-772-1213 or visit www.ssa.gov.
Unemployment Compensation	$	Copy of award letter/certificate, or monthly benefit statement from NYS Department of Labor, or Copy of Direct Payment Card with printout, or Correspondence from the NYS Department of Labor, or Printout of recipient's account information from the NYS Department of Labor's website (www.labor.state.ny.us).
Disability Payment	$	Copy of award letter/certificate, or correspondence from Social Security Administration, or copy of annual benefit letter. To request a copy of your benefit letter, call 1-800-772-1213 or visit www.ssa.gov.
Workers Compensation	$	Copy of Award Letter or Check stub.
Alimony/Child Support	$	Copy of court order, or 3 months of cashed checks/receipts.
Dividends/Interest	$	Quarterly dividend statements or 1 month statements.
Other	$	Letter stating the amount of non-wage earnings (if any), such as rental income, cash for odd jobs, etc.
No Income	$0	Signed statement of no income.