Northwell Health®

紐約州統一醫院財務援助申請表
(NYS UNIFORM HOSPITAL FINANCIAL ASSISTANCE APPLICATION)

如果您沒有保險、您的保險已用盡，或您擁有健康保險但已支付的醫療費用總額超過您收入的 10%，那麼您可能符合資格申請醫院財務援助以支付賬單。填寫此表格即可開始申請醫院財務援助。此表格適用於紐約州所有醫院。

此申請表必須以醫院服務對象的主要[1]語言印製。

患者姓名（填寫所有適用資料）

患者姓名（名、中間名、姓）		
出生日期（年/月/日）		
地址	公寓/單位號碼	
城市	州	郵遞區號
聯絡電話		
家長/監護人或法定代表人姓名（如患者為未成年兒童或無行為能力的成年人）		
電郵地址（如有）		

家庭資料：
請在下方列出您家中所有家庭成員。您的家庭成員包括您本人、配偶或同居伴侶，以及任何子女或其他受撫養人。例如，這包括所有列在同一份報稅表上的人。

總收入是指扣除稅款**前**的收入。

總收入可包括工作收入（工資、薪金、小費、自營職業收入）、非勞動收入（社會保障金、殘疾補助和失業福利）、資助（來自家人或朋友的資金）及其他收入來源（臨時援助和補充保障收入）。

[1]「主要語言」包括每年至少在 5% 的患者就診中使用的任何語言，或主要醫院服務區人口中超過 1% 使用的任何語言。
此數據是根據美國人口普查局提供的人口統計資料，並輔以學校系統的數據計算得出。

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紐約州統一醫院財務援助申請表
(NYS UNIFORM HOSPITAL FINANCIAL ASSISTANCE APPLICATION)

全名	與患者的關係	目前總收入
	本人	

醫院可能會要求您提交證明文件作為收入證明；證明文件例子可包括薪資明細、僱主信（如適用）或 1040 報稅表。

健康保險狀況
您是否有任何形式的健康保險？包括 Medicaid、Medicare，
或透過僱主提供或自行購買的私人保險？ ☐ 是 ☐ 否

如果您回答「否」，您是否希望在申請這些計劃時獲得協助？ ☐ 是 ☐ 否

保險覆蓋不足的患者：指擁有保險但醫療費用仍然高昂的人。
如果您有保險，請估算您在過去 12 個月已支付的醫療費用。

$

醫院可能會要求您提交證明文件，以證明已支付的醫療費用。

患者/責任方：如非患者本人，請列出簽署表格者的姓名及其代表患者簽署的授權（例如，配偶、父母、法定代表人）。

本人明白，本人提交的資料可能需要經外部來源核實。本人證明，據本人所知所信，以上資料均屬真實完整。

患者/代理人/親屬/監護人（簽名） (Patient/Agent/Relative/Guardian (Signature))	日期 (Date)	時間 (Time)	正楷書寫姓名 (Print Name)

如果簽字者不是患者本人，則說明與患者的關系
(Relationship if other than patient)

最低資格及指引
(MINIMUM ELIGIBILITY AND GUIDELINES)

申請時間表、患者權利及保密性

- 您可在收款過程中的任何時間申請財務援助。
- 在您收到財務援助申請結果之前，您無需向醫院支付任何款項。在您的申請處理期間，醫院不得將賬戶轉交收款。
- 如果您的財務援助申請被拒絕，您有權提出上訴。您收到的醫院通知中將載有上訴方法的資料。您亦可能有權就財務援助金額提出上訴。醫院將在其決定信中列明上訴方法的資料。
- 醫院在您收到第一張賬單後至少 180 天內，不得將未付賬單轉交收款機構。
- 醫院不得對收入低於聯邦貧困線 400% 的患者採取法律行動（包括提起訴訟）以追討未付的醫療費用。貧困線指引可在此網址查閱：https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines
- 此申請表中提供的任何資料僅供醫院用於確定您是否符合資格獲得財務援助，並會在法律允許的範圍內保密。
- 醫院不得因為您有未償還的醫療賬單而拒絕向您提供必需的醫療服務。
- 如果您需要協助填寫此申請表，**請致電 (800) 995-5727 聯絡 Northwell Health 的財務援助辦公室。**
- 請透過以下方式提交您的申請：致電上述電話號碼與代表聯絡、在 https://www.northwell.edu/assistance 網上申請，或郵寄至 Northwell Health Financial Assistance Unit, P.O. BOX 9001, Melville, NY 11747。
- 如果您需要額外協助填寫此申請表或協助上訴，可聯絡社區健康倡導者：888-614-5400。

資格

醫院有權為收入水平高於以下規定的患者設定獲得付款折扣的資格，及（或）為合資格患者提供比《公共衛生法》規定更大的付款折扣。此外，移民身份並非用於決定財務援助資格的準則。

以下人士符合資格：

- 沒有健康保險的低收入人士；或
- 保險覆蓋不足人士（過去十二個月累計的自付醫療費用超過其個人年度總收入的百分之十）；或
- 已用盡其健康保險福利，並且可以證明無力支付全部費用的人士；或
- 經醫院酌情決定，可以證明無力支付其共同支付額及（或）自付額的人士可以要求減少付款或獲得折扣。

收入達到聯邦貧困線 400% 的人士均有資格獲得財務援助。

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最低資格及指引
(MINIMUM ELIGIBILITY AND GUIDELINES)

聯邦貧困線（2025 年）			
家庭人數	**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：https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines

最低折扣率

如果您符合財務援助資格，您的費用將根據您的收入按滑動收費表減少，詳情如下：

收入水平	**付款**
低於聯邦貧困線 200%	豁免所有費用
聯邦貧困線 200% 至 300%	無保險患者：按 Medicaid 支付的服務費用金額的 10% 計算的滑動收費表。 保險覆蓋不足的患者：根據該患者的保險費用分攤支付金額的最高 10%。
聯邦貧困線 301% 至 400%	無保險患者：按 Medicaid 支付的服務費用金額的 20% 計算的滑動收費表。 保險覆蓋不足的患者：根據該患者的保險費用分攤支付金額的最高 20%。

醫院可選擇為合資格患者提供更高的折扣，及（或）為收入水平較高的患者提供付款折扣。

分期付款計劃

無法一次性支付減免後費用的患者可使用分期付款計劃。每月付款額不得超過您每月總收入的 5%，而患者未付餘額（如有）的利率不得超過 2%。

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家庭收入證明要求
(REQUEST FOR PROOF OF HOUSEHOLD INCOME)

請提供患者、其配偶和任何受撫養人（例如子女）的收入資料。例如，計算家庭收入時需包括同一份報稅表上的所有人（報稅人、配偶和稅務受撫養人）。

以下是可用於證明您收入的文件清單。您無需提供所有這些文件。如果您沒有收入，您也可以提供一份無家庭收入聲明。

您也可以提供紐約州健康保險交易市場 (NY State of Health Marketplace) 的資格確定頁面。如果您持有此文件，您無需向醫院提供以下列出的任何其他收入資料。

如果家庭收入來源為：	每月金額：	申請人可提供：
工資	$	請提供一張薪資明細、或公司抬頭紙上由僱主簽署並註明日期的信函、或最近提交的所得稅申報表。
社會保障金	$	授款函/證書副本、或美國社會保障局的信函、或年度福利信。如需索取您的社會保障福利信副本，請致電 1-800-772-1213 或瀏覽 www.ssa.gov。
失業補償金	$	授款函/證書副本、或紐約州勞工局的每月福利報表、或直接付款卡副本連同列印輸出、或紐約州勞工局的信函、或從紐約州勞工局網站 (www.labor.state.ny.us) 列印的受益人賬戶資料。
殘疾補助金	$	授款函/證書副本、或社會保障局的信函、或年度福利信副本。如需索取您的福利信副本，請致電 1-800-772-1213 或瀏覽 www.ssa.gov。
工傷賠償	$	授款函或支票存根副本。
贍養費或子女撫養費	$	法院命令副本，或 3 個月的已兌現支票或收據。
股息或利息	$	季度股息單或 1 個月股息單。
其他	$	說明非工資收入金額（如有）的信函，例如租金收入、零工現金報酬等。
無收入	$0	已簽署的無收入聲明。

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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.