Northwell Health®

APLIKASYON POU ASISTANS FINANSYE POU LOPITAL NYS UNIFORM
(NYS UNIFORM HOSPITAL FINANCIAL ASSISTANCE APPLICATION)

Ou ka elijib pou asistans finansye lopital pou peye fakti w yo si ou pa gen asirans, si w fin itilize asirans ou, oswa si ou gen asirans sante men ou gen prèv ki montre ou peye depans medikal an total ki plis pase 10% nan revni w. Lè w ranpli fòm sa a sa pral kòmanse demann ou pou asistans finansye lopital la. Tout lopital nan Eta New York itilize fòm sa a.

Aplikasyon sa a dwe enprime nan lang prensipal[1] pasyan lopital la sèvi a pale.

Non pasyan an (ranpli enfòmasyon ki aplikab)

Non pasyan an(Prenon, dezyèm prenon, siyati)		
Dat nesans (mm/jj/aaaa)		
Adrès	# Apatman/Inite	
Vil	Eta	Kòd Postal
# Telefòn pou kontak		
Non Paran/Gadyen oswa Reprezantan Legal (si pasyan an se yon timoun minè oswa yon adilt ki enkapab)		
Adrès Imèl (si genyen)		

Enfòmasyon sou Fanmi:
Tanpri site anba a tout manm fanmi ki abite nan kay la. Kay ou a gen ladann oumenm, mari oswa madanm ou oswa patnè domestik ou, ak nenpòt timoun oswa lòt depandan. Pa egzanp, sa ta gen ladan l tout moun ki site sou menm deklarasyon revni oswa taks.

Revni brit vle di revni ou **anvan** yo retire taks..

Revni brit ka gen ladan l lajan ou fè nan travay ou (salè, poubwa, salè nan travay endepandan), revni ou pa travay pou li (sekirite sosyal, envalidite, ak benefis chomaj), kontribisyon (lajan fanmi oswa zanmi w ba w), ak lòt sous revni (asistans tanporè ak revni sekirite siplemantè).

[1] “Lang Prensipal yo” gen ladan yo nenpòt lang yo itilize pou kominike nan omwen 5% vizit pasyan chak ane, oswa nenpòt lang plis pase 1% popilasyon zòn sèvis lopital prensipal la pale, jan yo kalkile sa ak enfòmasyon demografik ki disponib nan Biwo Resansman Etazini an, ak done ki soti nan sistèm lekòl yo.

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APLIKASYON POU ASISTANS FINANSYE POU LOPITAL NYS UNIFORM
(NYS UNIFORM HOSPITAL FINANCIAL ASSISTANCE APPLICATION)

Non konplè	Relasyon	Total revni brit (aktyèl)
	Oumenm	

Lopital la ka mande w pou soumèt dokiman kòm prèv revni; kèk egzanp dokiman yo ta ka gen ladan yo souchèk, yon lèt anplwayè w la bay si sa aplikab, oswa Fòm 1040.

Estati Asirans Sante
Èske w gen nenpòt fòm asirans sante, tankou Medicaid, Medicare, oswa asirans prive atravè anplwayè w oswa asirans ou achte poukont ou? ☐ Wi ☐ Non

Si w reponn “Non,” èske w ta renmen jwenn èd pou w aplike pou nenpòt nan pwogram sa yo? ☐ Wi ☐ Non

Pasyan ki pa gen ase asirans: moun ki gen asirans ak gwo depans medikal.
Si ou gen asirans, tanpri bay yon estimasyon fakti medikal ou te peye nan 12 mwa ki sot pase yo.

$

Lopital la ka mande w pou soumèt dokiman kòm prèv ou peye pou depans medikal yo.

Pasyan/Pati ki responsab: Si se pa pasyan an, site non moun k ap siyen fòm lan ak otorite yo genyen pou siyen nan non pasyan an (pa egzanp, mari oswa madanm, paran, reprezantan legal).

Mwen konprann enfòmasyon mwen soumèt yo ka sijè a verifikasyon ki sot nan sous ekstèn. Mwen sètifye enfòmasyon an se laverite epi li konplè dapre tout sa mwen konnen.

_____	_____	_____	_____
Pasyan/ajan/fanmi/gadyen* (Siyati) (Patient/Agent/Relative/Guardian (Signature))	Dat (Date)	Lè (Time)	Ekri non an lèt majiskil (Print Name)

_____
Relasyon si se pa pasyan an
(Relationship if other than patient)

ELIJIBILITE MINIMÒM AK DIREKTIV
(MINIMUM ELIGIBILITY AND GUIDELINES)

Kalandriye aplikasyon an, Dwa Pasyan an, ak Konfidansyalite

- Ou ka aplike pou asistans finansye a nenpòt moman pandan pwosesis koleksyon an.
- Ou pa oblije fè okenn peman nan lopital sa a jiskaske ou resevwa yon desizyon sou aplikasyon w lan pou asistans finansye. Lopital yo pa ka voye kont yo nan koleksyon pandan y ap travay sou aplikasyon w lan.
- Si yo refize ba w èd finansye, ou gen dwa pou fè apèl. N ap mete enfòmasyon sou fason pou w fè sa nan notis lopital la ou resevwa a. Ou ka gen dwa fè apèl konsènan montan asistans finansye ou resevwa a. Lopital la pral mete enfòmasyon sou fason pou fè apèl nan lèt desizyon y ap voye ba w la.
- Lopital yo pa kapab voye fakti ki poko peye bay yon ajans koleksyon pandan omwen 180 jou apre premye fakti ou te resevwa a.
- Yo entèdi lopital yo pou yo pran aksyon legal, tankou fè pwosè kont ou, pou rekipere fakti medikal ki poko peye pou pasyan ki pi ba pase 400% nivo povrete federal la. Ou ka jwenn direktiv povrete a la a: https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines
- Yo pral sèlman itilize nenpòt enfòmasyon ou bay nan aplikasyon sa a pou detèmine si w kalifye pou asistans finansye epi yo pral rete konfidansyèl nan limit lalwa pèmèt sa.
- Yon lopital pa ka refize w sèvis ki nesesè sou plan medikal paske ou gen yon fakti medikal ou poko peye.
- Si w bezwen asistans ak aplikasyon sa a, **tanpri kontakte Biwo Asistans Finansye Northwell Health nan (800) 995-5727.**
- Tanpri soumèt aplikasyon w lan lè w pale ak yon reprezantan nan nimewo telefòn ki anwo a, sou entènèt nan https://www.northwell.edu/assistance, oswa pa lapòs nan Northwell Health Financial Assistance Unit, P.O. BOX 9001, Melville, NY 11747
- Si w bezwen plis èd ak aplikasyon sa a oswa èd pou fè apèl a yon desizyon, ou ka kontakte Community Health Advocates: 888-614-5400.

Elijibilite

Pa gen anyen ki limite kapasite yon lopital genyen pou l etabli elijiblite pasyan an pou rabè sou peman nan nivo revni ki pi wo pase sa ki espesifye pi ba a epi/oswa pou bay pi gwo rabè sou peman pou pasyan ki elijib pase sa Lwa sou Sante Piblik egzije. Anplis de sa, estati imigrasyon pa dwe yon kritè elijiblite nan objektif pou detèmine èd finansye.

Moun ki pral site la yo elijib:

- Moun ki gen revni ba ki pa gen asirans sante; oswa
- moun ki pa gen ase asirans (depans medikal ki soti nan pòch yo akimile nan douz mwa ki sot pase yo ki monte a plis pase dis pousan revni anyèl brit moun sa a); oswa
- moun ki fin itilize tout benefis asirans sante yo, epi ki ka demontre yo pa kapab peye tout chaj yo; oswa
- selon diskresyon lopital la, moun ki ka demontre yo pa kapab peye kopeman yo epi/oswa franchiz yo ka mande yon peman redui oswa yon rabè sou peman.

Moun ki rive jiska 400% nivo povrete federal la kalifye pou asistans finansye.

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ELIJIBILITE MINIMÒM AK DIREKTIV
(MINIMUM ELIGIBILITY AND GUIDELINES)

Nivo povrete federal (2025)			
Kantite moun ki nan kay la	**200%**	**300%**	**400%**
1 Moun	$ 31,300	$ 46,950	$ 62,600
2 Moun	$ 42,300	$ 63,450	$ 84,600
3 Moun	$ 53,300	$ 79,950	$ 106,600
4 Moun	$ 64,300	$ 96,450	$ 128,600
5 Moun	$ 75,300	$ 112,950	$ 150,600
6 Moun	$ 86,300	$ 129,450	$ 172,600
7 Moun	$ 97,300	$ 145,950	$ 194,600

Yo fè mizajou chak ane: https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines

To Rabè Minimòm

Si w kalifye pou asistans finansye, yo pral redui frè w yo selon revni w sou yon echèl frè mobil nan fason sa a:

Nivo Revni	**Peman**
Anba 200% NPF	Anile tout chaj yo
200% - 300% NPF	Pasyan ki pa gen asirans: Echèl mobil jiska 10% nan montan lajan Medicaid t ap gen pou peye pou sèvis(yo). Pasyan ki pa gen ase asirans: Jiska yon maksimòm 10% nan montan lajan yo t ap gen pou peye dapre pataj frè asirans pasyan sa a.
301% - 400% NPF	Pasyan ki pa gen asirans: Echèl mobil jiska 20% nan montan lajan Medicaid t ap gen pou peye pou sèvis(yo). Pasyan ki pa gen ase asirans: Jiska yon maksimòm 20% nan montan lajan yo t ap gen pou peye daprè pataj frè asirans pasyan an.

Lopital yo ka chwazi bay pi gwo rabè pou pasyan ki elijib yo epi/oswa ofri rabè sou peman pou pasyan ki nan nivo revni ki pi wo.

Plan vèsman

Plan vèsman yo disponib pou pasyan ki pa kapab peye to redui a yon sèl kou. Peman mansyèl yo pa ka depase 5% revni brit ou pa mwa ak pousantaj enterè yo chaje pasyan an sou balans ki poko peye a, si genyen, pa dwe depase 2%.

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DEMANN POU PRÈV REVNI MOUN KI NAN KAY LA
(REQUEST FOR PROOF OF HOUSEHOLD INCOME)

Tanpri mete enfòmasyon sou revni pou pasyan an, konjwen yo ak nenpòt moun ki depandan yo (tankou timoun). Pa egzanp, sa a ta enkli tout moun ki sou menm deklarasyon taks (moun ki ranpli taks la, mari l oswa madanm li, ak depandan l pou taks) nan kalkil revni moun ki nan kay la.

Sa ki anba la a se yon lis dokiman ou ka itilize pou pwouve revni ou. Ou pa oblije bay tout dokiman sa yo. Ou kapab tou bay yon deklarasyon ki montre pa gen revni ki rantre nan kay la si ou pa gen revni.

Ou ka bay paj detèminasyon elijiblite a tou ki sot nan NY State of Health Marketplace. Si w genyen dokiman sa a, ou pa oblije bay lopital la okenn lòt enfòmasyon sou revni ki site anba a.

Si moun nan kay la resevwa:	Kantite lajan pa mwa:	Aplikan an ka bay:
Salè	$	Tanpri bay yon souchèk, oswa yon lèt ki soti nan men anplwayè w la sou papye antèt konpayi an, ki siyen epi ki gen dat, oswa dènye deklarasyon taks sou revni ou te ranpli.
Peman Sekirite Sosyal	$	Kopi lèt/sètifika, oswa korespondans Administrasyon Sekirite Sosyal Etazini voye ba w, oswa lèt benefis ou resevwa chak ane. Pou mande yon kopi lèt benefis Sekirite Sosyal ou a, rele 1-800-772-1213 oswa vizite www.ssa.gov.
Konpansasyon pou chomaj	$	Kopi lèt/sètifika, oswa deklarasyon benefis mansyèl ki soti nan Depatman Travay Eta New York, oswa kopi kat peman dirèk ki gen pati ki enprime, oswa korespondans ki soti nan Depatman Travay Eta New York, oswa kopi ki gen enfòmasyon sou kont resipyan an ki soti sou sitwèb Depatman Travay Eta New York (www.labor.state.ny.us).
Peman pou envalidite	$	Kopi lèt/sètifika, oswa korespondans Administrasyon Sekirite Sosyal, oswa kopi lèt benefis ou resevw chak ane. Pou mande yon kopi lèt benefis ou a, rele 1-800-772-1213 oswa vizite www.ssa.gov.
Konpansasyon pou aksidan yo fè nan travay	$	Kopi lèt la oswa souchèk.
Alimoni/Sipò alimantè pou timoun	$	Kopi òdonans tribinal la, oswa 3 mwa chèk ou chanje/resi yo.
Dividann/Enterè	$	Deklarasyon dividann chak trimès oswa deklarasyon 1 mwa.
Lòt	$	Lèt ki endike montan lajan ou resevwa ki pa lajan ou touche nan travay ou (si genyen), tankou revni lwaye, lajan kach ou touche pou ti travay ou fè nan brikolaj pasi pala, elatriye.
Pa gen revni	$0	Deklarasyon ki siyen ki fè konnen ou pa gen revni.

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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.