SITE:

MSBIB ☐	MSBI ☐	MSH NY ☐	MS NYEEI ☐
MSH Qns ☐	MSSL ☐	MSRH ☐	REAP ☐
	HEAL RH ☐	HEAL SL ☐	

HEALTH SYSTEM FINANCIAL ASSISTANCE APPLICATION

Date of Request: ______________________ Requested By: ______________________

Patient Name: ____
Last First Middle Initial

Address: ____
Street City State Zip Code

Type of Service Rendered/Requested: ( ) Inpatient ( ) Outpatient ( ) Ambulatory Surgery ( ) ED ( ) Special Services/Referred Ambulatory ( ) RTC/Dubin/MSBIMC Comprehensive Cancer Center West MSBIMC Radiology Oncology ( ) Other

Date(s) of Service:

____

Applicant Statement:

I certify that the above information is correct. I understand that the information, which I submit, is subject to verification by (**The Mount Sinai Health System** or its designees) and subject to review. Further, I will take all steps necessary to apply for any assistance (Medicaid, Medicare, Insurance, etc.) which may be available for payment of my hospital charges. I will take any action reasonably necessary to obtain such assistance and will assign or pay the hospital the amount recovered for hospital charges. I understand that if any of the information I have given proves to be untrue, the hospital may re-evaluate my financial status and take whatever action it deems appropriate. I understand that payments will not be required and that I can disregard all Hospital bills as long as my application is in process.

______________________ ______________________
Signature Date Print Name

____
Relationship

- -

ELIGIBILITY DETERMINATION (For Office Use Only)

Date Application Received: ______________________ Patient Number: ______________________

Family Income:

Current Monthly Income (wkly x 4.333)	Annual Income (based on current x 12)	Family Size

Income Verified: ( ) Yes ( ) No Type of Verification: ( ) Pay Stubs ( ) Other (specify below)

____

Family Composition Verified: ( ) Yes ( ) No

( ) The applicant is approved for a Financial Assistance discount under level ____ or F/C allocation ____.

( ) OPD/DTC visits approved at Category ( ) of the schedules.

( ) The applicant's request for Financial Assistance has been denied for the following reason(s).

____

Date of Determination: ______________________ Initiated By: ______________________
Print Name and Sign

Authorization period ______________________ Reviewed/Approved By: ______________________
Print Name and Sign

Exception to policy reason ______________________ Approved by ______________________

Applications must be filed within 240 days from the point of service. Applications must be completed within 30 days from the point of application. If this application is denied, please follow the appeal instructions attached hereto. Denials MUST be appealed within 30 days of the adverse decision in accordance with Part 10 of the policy.

IF YOUR APPEAL IS UNSUCCESSFUL OR, IF YOU DO NOT AGREE WITH THE DECISION; YOU MAY CONTACT THE NYS DEPARTMENT OF HEALTH AT 1-800-804-5447