MONTEFIORE MEDICAL CENTER
FINANCIAL AID APPLICATION

APPLICANT INFORMATION						
Patient Name				Date of Birth:		
Address				Apt#		
City			State		ZIP	
Phone		Relationship to Patient	*Self Spouse Child Parent Grandparent Grandchild Other*			
Current Insurance Coverage:		Family Size		Balance Owed		

ELIGIBILITY WORKSHEET: FOR OFFICE USE ONLY				
Financial Counselor	Referral Source:		Adjusted Account Balance	
Patient MRN		HAR Number		DOS:
Proof of Income Secured	Yes No	Supporting Documentation	1. Pay-stubs 2. Job Letter 3. Marketplace Documentation 4. Letter of Support (If Applicable) Other (Specify):	
Verified Gross Annual Income				
The Applicant is approved for Financial Aid at the following category level (1-10)				
Application Request Date			Proof of Income Received Date	
Application Received Date			Account Adjusted Date	

Financial Aid Notification Date		**Approval/Denial Date:**	
Approved by:			

APPLICATION STATEMENT

My signature on this application reaffirms my authorizations for assignment of benefits and release of information related to medical services provided at Montefiore Medical Center.

While I am eligible for Financial Aid, I agree to inform Montefiore Medical Center of any changes in my family status in regard to family size, changes of income, and health coverage that could change my eligibility for Financial Aid. I authorize my employer and my health insurer to give Montefiore Medical Center information about income, health insurance premiums, coinsurance, co-payments, deductibles, and covered benefits that I have.
If I am seeking Financial Aid because of an accident or other incident and I receive money because of that accident or incident from any sources such as Worker's Compensation or an insurance carrier, I will repay Montefiore Medical Center for any medical services provided at Montefiore Medical Center and paid for or adjusted by Financial Aid.

All information in this application is true to the best of my knowledge and I agree to provide documentation upon request.

Patients Printed Name		**Date**	
Signature of Patient			
I am legally authorized to provide consent of behalf of the patient listed above. My relationship to the patient is described as follows:			
Signature of Authorized Representative		**Date**	
Relationship to Patient			

Complete this application and return with proof of income/support to any of the Patient Financial Services Offices at any of the following Montefiore locations:

Moses Campus	**Wakefield Campus**	**Weiler Campus**	**Westchester Square Campus**
111 East 210th Street	600 East 233rd Street	1825 Eastchester Road	2475 Saint Raymond Ave
Bronx, NY 10467	Bronx, NY 10466	Bronx, NY 10461	Bronx, NY 10461
718-920-5658	718-920-9660	718-904-3551	718-430-7339

Once you have submitted a completed application and documentation, you may disregard any bills until the hospital has rendered a decision on your application. Please complete application within 30 days.