MONTEFIORE MEDICAL CENTER
FINANCIAL AID APPLICATION

APPLICANT INFORMATION							
Patient Name				Social Security Number			
Address			Apt#		Date of Birth:		
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		Account Number		DOS:	
Proof of Income Secured	Yes No	Supporting Documentation	1. Income Taxes 2. Pay-stubs		
Verified Gross Annual Income			Other (Specify):		
The Applicant is approved for Financial Aid at the following category level (1-6, 9M)					
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 IRS Form 8821 and return to the following address:

Montefiore Medical Center, Patient Financial Services Department 111 East 210th St Bronx NY 10467

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 with in 30 days.

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