South Nassau COMMUNITIES HOSPITAL
where quality matters

APPLICATION FOR FINANCIAL ASSISTANCE

Date of Application _____ Hospital Account # _____

Patient's Name _____ Applicant's Name _____

Address _____
Number and Street City State Zip Code

Telephone # _____ Employer Name & Telephone # _____

Income: List combined income for yourself, spouse and other dependents from:

	Total-last 3 months
Wages	$ _____
Self Employment Earnings	$ _____
Public Assistance	$ _____
Social Security	$ _____
Unemployment/Worker's Comp	$ _____
Alimony	$ _____
Child Support	$ _____
Military Family Allotments	$ _____
Pensions	$ _____
Income From Dividends, Interest, Rent	$ _____

As a condition to providing Financial Assistance you are required to submit proof of income/resources: (1) income tax returns including W-2's for the past year, (2) pay stubs, Social Security checks, Unemployment or Compensation papers for the past 3 consecutive months (3) other proof as requested. Proof means copies.

Family Size: Family members living in your household

Name	Age	Relationship

If additional space is needed, please attach another sheet.

I hereby request that South Nassau Communities Hospital make a written determination of my eligibility for Financial Assistance. I understand that the information, which I submit concerning my annual income and family size is subject to verification by the hospital and that Financial Assistance, is offered at the discretion of the hospital. I also understand that if the information, which I submit is determined to be false, such determination will result in a denial and that I will be liable for charges for services provided. I affirm that the above information is true and correct to the best of my knowledge. Further, I hereby give my permission to South Nassau Communities Hospital to verify any information contained above.

Date: _____ Signature of Applicant _____