For Hospital Use Only:	
Pt Name:	
Account #:	
Date Mailed/Given to Pt:	
By Whom:	
Dept:	



Financial Assistance Application

Nathan Littauer Hospital is committed to providing medical care to those patients who may not have sufficient financial resources to meet their medical care needs. To apply for Financial Assistance for your hospital account(s), The Financial Assistance Application must be completed fully, signed and returned to the hospi Please return all supporting documents with the application.

Upon review of the application, further information may be requested of you. Any potential source of payment, including state and federal assistance programs, all insurance sources, and legal settlements, must be exhausted before forgiveness of account balances will be considered. Your application for assistance will be given equal consideration in a non-discriminatory manner. Please understand that this application is for consideration of the Hospital charges only and DOES NOT cover billing from your private physician, radiologist, emergency room physician, consulting physician, hospital retail pharmacy or any other services not

Patient Name (Last, First,MI)			
Social Security#	Date of	Birth	
Address			erent than residence)
County of residence	Home p	phone	
Employer	Phone		How long?
Previous Employer	Phone		How long?
Spouse's Employer	Phone		. Total longs
opeace of Employer			1000 110 U 110 I
Address City/State/Zip Attorney Name/Address/Phone# Nature of Injury or Accident	Household Members And Income	Phone# Insured Police R	eport#
Worker's Compensation, Unemployment	Compensation, pensions, rental income	e, interest from i	er, including non-employment sources, such as investments, dividends, trust funds, child suppor
Worker's Compensation, Unemployment alimony, income from Social Security, Ve	Compensation, pensions, rental income	e, interest from i rogram.	investments, dividends, trust funds, child suppor
Worker's Compensation, Unemployment alimony, income from Social Security, Ve Family Members	Compensation, pensions, rental income	e, interest from i rogram. Monthly	investments, dividends, trust funds, child suppor Gross Income
Worker's Compensation, Unemployment alimony, income from Social Security, Ve	Compensation, pensions, rental income	e, interest from i rogram.	investments, dividends, trust funds, child suppor
Worker's Compensation, Unemployment alimony, income from Social Security, Ve Family Members Self	Compensation, pensions, rental income eterans Administration or other benefit p	e, interest from i rogram. Monthly \$	investments, dividends, trust funds, child suppor Gross Income Source
Worker's Compensation, Unemployment alimony, income from Social Security, Ve Family Members Self Husband/Father	Compensation, pensions, rental income eterans Administration or other benefit p	e, interest from i rogram. Monthly \$	investments, dividends, trust funds, child suppor Gross Income Source Source
Worker's Compensation, Unemployment alimony, income from Social Security, Ve Family Members Self Husband/Father Wife/Mother	Compensation, pensions, rental income eterans Administration or other benefit p	e, interest from rogram. Monthly \$ \$	round of the state
Worker's Compensation, Unemployment alimony, income from Social Security, Ve Family Members Self Husband/Father Wife/Mother Dependant Children	Compensation, pensions, rental income eterans Administration or other benefit p SSN SSN	e, interest from rogram. Monthly \$ \$	round of the state
Worker's Compensation, Unemployment alimony, income from Social Security, Ve Family Members Self Husband/Father Wife/Mother Dependant Children Name	Compensation, pensions, rental income eterans Administration or other benefit p SSN SSN Date of Birth	e, interest from rogram. Monthly \$ \$	investments, dividends, trust funds, child suppor Gross Income Source Source Source Source
Worker's Compensation, Unemployment alimony, income from Social Security, Veramily Members Self Husband/Father Wife/Mother Dependant Children Name	SSN SSN Date of Birth Date of Birth	e, interest from rogram. Monthly \$ \$	investments, dividends, trust funds, child suppor Gross Income Source Source Source Source
Worker's Compensation, Unemployment alimony, income from Social Security, Veramily Members Self Husband/Father Wife/Mother Dependant Children Name Name Name	Compensation, pensions, rental income eterans Administration or other benefit possible. SSN SSN Date of Birth Date of Birth Date of Birth Date of Birth	e, interest from rogram. Monthly \$ \$	Gross Income Source Source Source Source Total Monthly Gross Income
Worker's Compensation, Unemployment alimony, income from Social Security, Verantly Members Self Husband/Father Wife/Mother Dependant Children Name Name Name Other children	Compensation, pensions, rental income eterans Administration or other benefit possible. SSN SSN Date of Birth	e, interest from rogram. Monthly \$ \$	Gross Income Source Source Source Source Total Monthly Gross Income
Worker's Compensation, Unemployment alimony, income from Social Security, Verantly Members Self Husband/Father Wife/Mother Dependant Children Name Name Name Other children Name	Compensation, pensions, rental income eterans Administration or other benefit possible. SSN SSN Date of Birth Date of Birth Date of Birth Date of Birth	e, interest from rogram. Monthly \$ \$	Gross Income Source Source Source Source Total Monthly Gross Income

Financial Assistance Application

	•	bility Y / N	Victims Compensation	on Y/I
ease list any recent accounts the imary Care sites.	at you or your immediate far	nily members may have at Nal	ihan Littauer Hospital or one	e of our
atient Name	Accor	unt #	Date of Service	
				.
certify that the above information and requirements set forth in the rignature of applicant:		cial Assistance.		
or Hospital Use Only: Refe		SI() Victim's Comp() Approved	Other	
or Hospital Use Only: Refer	rred to DSS () SS Reviewed () ()	Approved () ()	Denied ()	
For Hospital Use Only: Refer	rred to DSS () SS Reviewed () ()		Denied ()	

For Hospital Use Only:	
Pt Name:	
Account #:	
Date Mailed/Given to Pt:	
By Whom:	•
Dept:	

Patient Name (Last, First, MI)

Social Security #



Its worth to have never U.

Medicare Financial Assistance Application

Nathan Littauer Hospital is committed to providing medical care to those patients who may not have sufficient financial resources to meet their medical care needs. To apply for Financial Assistance for your hospital account(s), The Financial Assistance Application must be completed fully, signed and returned to the hospital Please return all supporting documents with the application.

Date of Birth

Upon review of the application, further information may be requested of you. Any potential source of payment, including state and federal assistance programs, all insurance sources, and legal settlements, must be exhausted before forgiveness of account balances will be considered. Your application for assistance will be given equal consideration in a non-discriminatory manner. Please understand that this application is for consideration of the Hospital charges only and DOES NOT cover billing from your private physician, radiologist, emergency room physician, consulting physician, hospital retail pharmacy or any other services not provided by the hospital.

For questions or to inquire about the status of your application, please call 518-773-5551

Address	Mailing	Mailing Address (If different than residence)		
County of residence	Home	phone		
Employer	Phone		How long?	
Previous Employer	Phone		How long?	
Employer/Spouse	Phone			
	Insurance			
			tion is the result of an injury or accident, please	
provide us with the necessary Auto/Home	owner's, Workers Compensation or	Third Party insur	rance below:	
Insurance Co.		Policy#		
Address		Phone#		
City/State/Zip		Insured	SSN#	
Attorney Name/Address/Phone#				
Nature of Injury or Accident		Police Re	eport#	
	Household Members And Income	e Information		
Please list all household members and inc	clude all sources of income for each	household mem	ber, including non-employment sources, such as	
Worker's Compensation, Unemployment (Compensation, pensions, rental inco	me, interest fron	n investments, dividends, trust funds, child support,	
alimony, income from Social Security, Vet	lerans Administration or other benefi	t program.		
Family Members		Monthly	Gross Income	
Self		\$	Source	
Husband/Father	SSN	\$	Source	
Wife/Mother	SSN	\$	Source	
Dependant Children		\$	Source	
Name	Date of Birth			
Name	Date of Birth		Total Monthly Gross Income	
Name	Date of Birth			
Other children			\$	
Name	Date of Birth			
Name	Date of Birth			
Name	Date of Birth		·	
Total Family Members				
	·			

Medicare Financial Assistance Application

Bank Name	•	Checking Acct #	Avg Bal. Sa	ving Acct. #	Avg Bal.
	-			• **-	
	-				<u> </u>
Assets	-	-		Total	-
Vehicles Make		Model	Year	Pmt. Amt.	Bal Due
Make		Model	Year	Pmt. Amt.	Bal Due
Other Assets	(Stocks, I	Bonds,Property,Boat, Buisiness	etc.)		
Monthly Expens	es				
λ.		Monthly Payment	Payment To	Acct. #	Bal Due
Mortgage/Rent Credit Cards	•				
Credit Cards					
			<u></u>		
					•
Bank Loans					·
School Loans					
Other Monthly Ex	penses				
				·	

Note: Attach additional sheet if necessary. Important: remember to attach supporting documentation.

Medicare Financial Assistance Application

Medicaid Y / N		ring the past year?	Date of application:	
	Social Securi	ty Disability Y / N	Victims Compensation	ו
lease list any recent acc rimary Care sites.	counts that you or your immedia	ate family members may hav	e at Nathan Littauer Hospital or one	of o
atient Name		Account #	Date of Service	
	ormation is true and accurate t h in the notice of availability of		I have read and agree to comply wil	h al
ignature of applicant:				
Date:		_	•	
or Hospital Use Only:	Referred to DSS ()	SSI() Victim's Com	o() Other	
	Referred to DSS () Reviewed	SSI() Victim's Comp	O() Other	
cct Number	Reviewed ()		Denied	
cct Number	Reviewed	Approved		
cct Number	Reviewed () () () ()	Approved	Denied ()	
acct Number	Reviewed () () () ()	Approved	Denied ()	
	Reviewed () () () ()	Approved	Denied ()	

For Hospital Use Only:	
Pt Name:	
Account #:	
Date Mailed/Given to Pt:	-
By Whom:	
Dept:	



Financial Assistance Application - Short Form

	mancial Assistance	Application - Short F	OHA		
Dear Patient:				126	
We ask that you complete the form below if you are eligible for our Financial Assista		counts-Financial Assistance	Office. We will review the	information and dete	
Patient Name		Marital Status	(please check one):	Married	
Social Security #		-		Separated Widowed	
City/State/Zip		•		Divorced Single	
Phone #		* Current Monthly Household Income			
County of residence	Total Yearly Hou	arly Household Income			
# of Dependents under 18 years _	Employer Name	,			
Have you filed for any state or fed	eral assistance durin	g the past year?	Date of application		
Medicaid Y / N S	ocial Security Disability	Y / N	Victim's Compensation	1 Y / N	
I certify that the above information is true and requirements set forth in the notice of			and agree to comply with	all terms	
Signature of applicant:			_		
Date:					
For Hospital Use Only: Referred to D	ess () ssi()	Victim's Comp ()	Other		
Acct Number	Reviewed	Approved	Denied		
	()	()	() _	,_	
Patient/Parent/Guardian Signature		Date	_		

* May require verification