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

NATHAN LITTAUER Hospital & Nursing Home

It's your life. Live it well.™

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 Applicaton 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 provided by the hospital.**

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

Patient Name (Last, First,MI)		
Social Security #	Date of Birth	
Address	Mailing Address (If different than residence)	
County of residence	Home phone	
Employer	Phone	How long?
Previous Employer	Phone	How long?
Spouse's Employer	Phone	

Insurance

If you have medical insurance, please provide that information below. Also, if your hospitalization is the result of an injury or accident, please provide us with the necessary Auto/Homeowner's, Workers Compensation or Third Party insurance below:

Insurance Co.		Policy #	
Address		Phone#	
City/State/Zip		Insured	SSN#
Attorney Name/Address/Phone#			
Nature of Injury or Accident		Police Report#	

Household Members And Income Information

Please list all household members and include all sources of income for each household member, including non-employment sources, such as Worker's Compensation, Unemployment Compensation, pensions, rental income, interest from investments, dividends, trust funds, child support, alimony, income from Social Security, Veterans Administration or other benefit 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		
Name	Date of Birth		
Other children			
Name	Date of Birth		
Name	Date of Birth		
Name	Date of Birth		
Total Family Members			

Total Monthly Gross Income

$

Financial Assistance Application

Have you filed for any state or federal assistance during the past year? Date of application: _____

Medicaid Y / N Social Security Disability Y / N Victims Compensation Y / N

Please list any recent accounts that you or your immediate family members may have at Nathan Littauer Hospital or one of our Primary Care sites.

Patient Name	**Account #**	**Date of Service**

I certify that the above information is true and accurate to the best of my knowledge. I have read and agree to comply with all terms and requirements set forth in the notice of availability of Financial Assistance.

Signature of applicant: _____

Date: _____

For Hospital Use Only: Referred to DSS ( ) SSI ( ) Victim's Comp ( ) Other _____

Acct Number	Reviewed	Approved	Denied	
	( )	( )	( )	
	( )	( )	( )	
	( )	( )	( )	
	( )	( )	( )	
	( )	( )	( )	
	( )	( )	( )	

_____

Patient/Parent/Guardian Signature Date

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

NATHAN LITTAUER Hospital & Nursing Home

It's your life! Live it well!

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 Applicaton must be completed fully, signed and returned to the hospital** 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 provided by the hospital.**

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

Patient Name (Last, First,MI)		
Social Security #	Date of Birth	
Address	Mailing Address (If different than residence)	
County of residence	Home phone	
Employer	Phone	How long?
Previous Employer	Phone	How long?
Employer/Spouse	Phone	

Insurance

If you have medical insurance, please provide that information below. Also, if your hospitalization is the result of an injury or accident, please provide us with the necessary Auto/Homeowner's, Workers Compensation or Third Party insurance below:

Insurance Co. _____ Policy # _____

Address _____ Phone# _____

City/State/Zip _____ Insured _____ SSN# _____

Attorney Name/Address/Phone# _____

Nature of Injury or Accident Police Report#

Household Members And Income Information

Please list all household members and include all sources of income for each household member, including non-employment sources, such as Worker's Compensation, Unemployment Compensation, pensions, rental income, interest from investments, dividends, trust funds, child support, alimony, income from Social Security, Veterans Administration or other benefit 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		
Name	Date of Birth		
Other children			
Name	Date of Birth		
Name	Date of Birth		
Name	Date of Birth		
Total Family Members			

Total Monthly Gross Income

$ _____

Medicare Financial Assistance Application

Bank Name	Checking Acct #	Avg Bal.	Saving Acct. #	Avg Bal.

Assets **Total**

Vehicles Make _____ Model _____ Year _____ Pmt. Amt. _____ Bal Due _____

Make _____ Model _____ Year _____ Pmt. Amt. _____ Bal Due _____

Other Assets (Stocks, Bonds,Property,Boat, Buisiness etc.)

_____

_____

Monthly Expenses

	Monthly Payment	Payment To	Acct. #	Bal Due
Mortgage/Rent				
Credit Cards				
Bank Loans				
School Loans				
Other Monthly Expenses				

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

Medicare Financial Assistance Application

Have you filed for any state or federal assistance during the past year? Date of application: _____

Medicaid Y / N Social Security Disability Y / N Victims Compensation

Please list any recent accounts that you or your immediate family members may have at Nathan Littauer Hospital or one of our Primary Care sites.

Patient Name	**Account #**	**Date of Service**

I certify that the above information is true and accurate to the best of my knowledge. I have read and agree to comply with all te and requirements set forth in the notice of availability of Financial Assistance.

Signature of applicant: _____

Date: _____

For Hospital Use Only: Referred to DSS ( ) SSI ( ) Victim's Comp ( ) Other _____

Acct Number	Reviewed	Approved	Denied	
	( )	( )	( )	
	( )	( )	( )	
	( )	( )	( )	
	( )	( )	( )	
	( )	( )	( )	
	( )	( )	( )	

_____

Patient/Parent/Guardian Signature Date

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

NATHAN LITTAUER
Hospital & Nursing Home

Financial Assistance Application - Short Form

Dear Patient:

We ask that you complete the form below and return it to Patient Accounts-Financial Assistance Office. We will review the information and dete if you are eligible for our Financial Assistance program.

Patient Name _____

Social Security # _____

City/State/Zip _____

Phone # _____

County of residence _____

# of Dependents under 18 years _____

Marital Status (please check one):
- ☐ Married
- ☐ Separated
- ☐ Widowed
- ☐ Divorced
- ☐ Single

* Current Monthly Household Income _____

Total Yearly Household Income _____

Employer Name _____

Have you filed for any state or federal assistance during the past year?

Date of application _____

Medicaid Y / N

Social Security Disability Y / N

Victim's Compensation Y / N

I certify that the above information is true and accurate to the best of my knowledge. I have read and agree to comply with all terms and requirements set forth in the notice of availability of Financial Assistance.

Signature of applicant: _____

Date:

For Hospital Use Only: Referred to DSS ( ) SSI ( ) Victim's Comp ( ) Other

Acct Number	Reviewed	Approved	Denied	
_____	( )	( )	( )	_____

_____

Patient/Parent/Guardian Signature Date

* May require verification