NATHAN LITTAUER
Hospital & Nursing Home

For Hospital Use Only:
Patient 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, signed and returned to the hospital. Please return all supporting documents with the application. Upon filing a completed application, you may disregard any Nathan Littauer Hospital bills until you receive notification of determination of your application. **APPLICATION AND DOCUMENTATION MUST BE RETURNED TO NATHAN LITTAUER HOSPITAL, 99 E. STATE ST, GLOVERSVILLE, NY 12078 ATTN: PATIENT FINANCIAL SERVICES.**

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 directly 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 from 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
Dependent 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: _____

Account Number	Reviewed	Approved	Denied	
	☐	☐	☐	
	☐	☐	☐	
	☐	☐	☐	
	☐	☐	☐	
	☐	☐	☐	
	☐	☐	☐	
	☐	☐	☐	

_____ _____

Patient/Parent/Guardian Signature Date