For Internal use only
Account #_____

NYU Langone Health Faculty Group Practice
Financial Assistance Application

Please mail or fax completed application to:

NYU Physician Services
P.O. Box 415662
Boston, MA 02241
Fax #: 678-459-0963

Patients treated in the NYU Langone Health Faculty Group Practice (FGP) are responsible for paying all applicable out-of-pocket costs associated with their care including copayments, co-insurances and/or deductibles.

The FGP Financial Assistance Program provides discounts for low-income individuals who do not have health insurance or who have exhausted their health insurance benefits and meet certain income guidelines for eligible services. Exclusions to this program include, but are not limited to, non-covered services and elective procedures for patients who are enrolled in insurance plans which providers do not contract with.

To be eligible, a patient must reside in New York State or the state in which the service(s) were provided, and be a US Citizen or legal resident. We will consider applications on a case-by-case basis. This application does not apply to any NYU Langone Health Hospital balances.

To ensure timely processing, please **submit all requested documentation within 14 days.**

Patient Information					
	Name (Last, First, MI)			**Date of Request**	
	Street Address		**City**	**State**	**Zip**
	Home Phone **( )** **Preferred ☐**	**Work Phone** **( )** **Preferred ☐**		**Cell Phone** **( )** **Preferred ☐**	
	SSN	**Date of Birth**	**Marital Status** **☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Partner ☐ Other:**		

Financial Information			
	Patient Employment Status ☐ Full-time ☐ Part-time ☐ Unemployed ☐ Retired ☐ Other:	**Guarantor** Employment Status ☐ Full-time ☐ Part-time ☐ Unemployed ☐ Retired ☐ Other:	
	Spouse Employment Status ☐ Full-time ☐ Part-time ☐ Unemployed ☐ Retired ☐ Other:	Monthly Salary/Unemployment/Disability Income	
	Last Day Worked (if applicable)	Household Size	Total Household Income

Complete applications must include one of the following documents:

1. Copies of pay stubs for the past month
2. Most recent W2 Forms and/or 1099s
3. Unemployment Documentation
4. Most Recent Tax Return
5. Copies of Medicaid, Family Health Plus or Child Health Plus application materials
6. Social Security Income / Disability

CERTIFICATION

I certify that the above information is true and accurate to the best of my knowledge. I also certify that the information entered on the application coincides with my supporting documents. I understand that fraudulent or misleading information will make me ineligible for any financial assistance. *I understand that incomplete applications or missing supporting documents are unable to be processed.* I authorize the release of any information needed to verify the information provided and for billing and collections in compliance with applicable federal and state laws.

I understand that this application is made so that the Faculty Group Practice can determine my eligibility for Financial Assistance based on the established criteria on file.

In addition, I agree to provide additional information as requested in order to determine eligibility within 14 days. I agree to inform NYU Langone Health Faculty Group Practice (FGP) of any change in my needs, insurance eligibility, income, property, and living arrangements or address as they occur.

Please contact our customer service team at (877)-648-2964 with questions about your application.

By signing below, I acknowledge that the information I provided is correct to the best of my ability.

Patient Signature: _____ **Date:** _____/_____/_____

Guarantor Signature (if other than patient): _____ **Date:** _____/_____/_____