



The Brooklyn Hospital Center

Keeping Brooklyn healthy.

**Patient & Family Service Center
718-250-8080**

Financial Aid - Patient Notice

Thank you for making The Brooklyn Hospital Center (TBHC) your hospital of choice!

TBHC is proud of its mission as we are dedicated to providing outstanding health services, education, and research to keep the people of Brooklyn and greater New York healthy.

If you do not have health insurance and worry that you may not be able to pay for your care, we may be able to help. TBHC provides financial aid to patients based on their income, assets and needs. In addition, we may be able to help you get free or low cost health insurance or work with you to arrange a manageable payment plan.

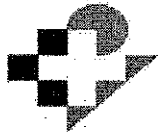
It is important that you let us know if you will have trouble paying your bill(s). Federal and state law requires all hospital to seek full payment of services billed to patients. This means we may turn any and all unpaid bills over to a collections agency, which could affect your credit status.

As a self pay patient all payments for all services are due on or before the day of your appointment.

For more information or to apply for apply for financial aid / charity care, please contact us in our financial counseling office at (718) 250-8080.

We will treat all your questions with confidentiality and courtesy.

Thank you!
Patient Financial Services



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Financial Screening Documentation Checklist

Please submit the following documentation to assist you for "possible" Financial Aid / Charity Care. Failure to submit or incomplete documentation may disqualify your application.

Patient must have items as stated from each of the following categories:

Δ Picture ID (Valid Driver's license, passport state ID, etc...)

Δ Proof of Address – Copies of **two** of the following

- 2 copies of your most recent utility bills (paid or unpaid) i.e. light bill, gas bill, cable bill, phone bill and or your lease.
- Driver's License
- Voter Registration Card or Naturalization Card
- If residing under someone else's address, a notarized letter from them **and** a copy of their two most recent utility boards.

Δ Proof of Income – A copy of **one** of the following

- W2/1099 Forms
- Current year 1040 US Federal Income Tax returns
- Last 6 pay stubs or Unemployment Benefits (state date)
- SS/SSI/SSD/VA Award letter
- Railroad Retirement Benefits Statements
- Pension/ Retirement Benefits Statements
- Rental Income or Mortgage Statements
- Forms approving or denying unemployment compensation
- Forms approving or denying workmen's compensation

EXCLUSIONS from FAP:
 Dental
 Cosmetic Surgery
 Anesthesia
 Physician Bill
 Prescriptions

If you are under 18 (EIGHTEEN) years of age, AND/OR you are dependent on your parent(s), then they must fill out the eligibility request form and provide the necessary documents.

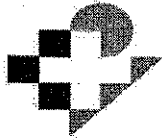
A telephone number where you can be reached **MUST BE PROVIDED**, as well as complete addresses, such as apartment numbers and letters

PLEASE RETURN THIS FORM WITH YOUR DOCUMENTS

(To be completed by TBHC Employee Only)

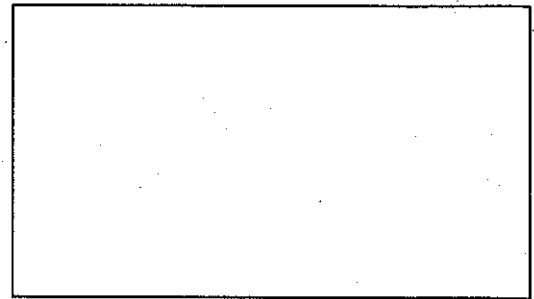
Date & Time scheduled for return of documents: _____

Financial Counselor's Signature: _____ Date: _____



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Financial Assistance
Application Form

Patient's Name _____

SS#: _____ Last _____ First _____ M.I. _____
 D.O.B _____ Sex _____

Address _____
 Number and Street, Apt City State Zip

Telephone No. () _____ Cell# _____ Occupation: _____

Employer _____ Employer Address _____ Tel# _____

Income-List combined income for yourself, spouse and all other household members from:

	Total-Last 3 mths	Total-Last 12 mths
WAGES		
SELF EMPLOYMENT EARNINGS		
PUBLIC ASSISTANCE		
SOCIAL SECURITY		
UNEMPLOYMENT/WORKMAN'S COMP.		
STRIKE BENEFITS		
ALIMONY		
CHILD SUPPORT		
MILITARY FAMILY ALLOTMENTS		
PENSIONS		
INCOME FROM DIVIDENDS		
RESOURCES (Bank Acts, Investments, Homes, etc)		
TOTAL INCOME		

FAMILY SIZE - Family members living in your household

NAME	AGE	RELATIONSHIP

NOTE: Please attach additional sheet if needed.

I HEREBY REQUEST THAT THE BROOKLYN HOSPITAL CENTER MAKE A WRITTEN DETERMINATION OF MY BLEIGIBILITY FOR FINANCIAL AID. I UNDERSTAND THAT THE INFORMATION WHICH I SUBMIT CONCERNING MY ANNUAL INCOME AND FAMILY SIZE IS SUBJECT TO VERIFICATION BY THE HOSPITAL. I ALSO UNDERSTAND THAT IF THE INFORMATION WHICH I SUBMIT IS DETERMINED TO BE FALSE, SUCH DETERMINATION WILL RESULT IN A DENIAL OF FINANCIAL AID 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 THE BROOKLYN HOSPITAL CENTER TO VERIFY ANY INFORMATION PERTINENT TO THIS APPLICATION.

DATE: _____ SIGNATURE OF APPLICANT _____