



GRACIE SQUARE HOSPITAL
APPLICATION FOR FINANCIAL AID

Patient's Name Last First Middle Init. Date of Birth

Address Number and Street, Apt. # City State Zip

Telephone No. ( ) Occupation Employer

Employer Address Employer Tel #

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

Table with 3 columns: Type of Income, Total Last 3 Months, Total Last 12 Months. Rows include Wages, Self-employment Earnings, Public Assistance, Social Security, Unemployment/Workers' Compensation, Alimony, Child Support, Pensions, Income From Dividends, Total.

Hospital requests that you submit documentation to substantiate the income you entered above. Examples of documentation might include pay stub, letter from employer if applicable, Form 1040, etc.

Family Size - Family members living in your household:

Table with 3 columns: Name, Age, Relationship. Multiple empty rows for data entry.

Note: Please attach another sheet if additional space needed.

THIS APPLICATION MAY BE SUBMITTED TO THE HOSPITAL AT ANY TIME DURING THE BILLING AND COLLECTION PROCESS.

ONCE YOU HAVE SUBMITTED A COMPLETED APPLICATION AND SUPPORTING DOCUMENTATION TO THE HOSPITAL AT THE ADDRESS BELOW, YOU MAY DISREGARD ANY BILLS UNTIL THE HOSPITAL HAS RENDERED A WRITTEN DECISION ON YOUR APPLICATION.

TO SUBMIT THIS APPLICATION FOR FINANCIAL AID, PLEASE READ THE FOLLOWING STATEMENT AND SIGN WHERE INDICATED BELOW.

I HEREBY REQUEST THAT GRACIE SQUARE HOSPITAL MAKE A WRITTEN DETERMINATION OF MY ELIGIBILITY 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 MAY BE LIABLE FOR CHARGES FOR SERVICES PROVIDED. I AFFIRM THAT THE INFORMATION ABOVE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. FURTHER, I HEREBY GIVE MY PERMISSION TO GRACIE SQUARE HOSPITAL TO VERIFY ANY INFORMATION PERTINENT TO THIS APPLICATION.

Date Signature of Applicant Account #

Completed Application to be sent to:

Gracie Square Hospital Patient Financial Services
100 Jericho Quadrangle, Suite 202
Jericho, NY 11753
Att: George Plunkett
Or FAX to : (516) 801-8504