



Financial Aid Application

Name _____

Address _____

Phone _____

Family size / number in household _____

	Patient Income	Spouse Income
Wages		
Social Security payment		
Unemployment compensation		
Disability		
Workers compensation		
Alimony/child support		
Dividends/interest/rentals		
All other income		
Total		

I affirm that the above information is true, complete, and correct to the best of my knowledge.

Signed _____ Date _____

If you have questions or need help completing this application, call the Financial Investigation Office at 718-206-8270 or (718) 206- _____.

If you have received a bill or bills from the hospital, check here: _____

Account Number: _____

You do not have to make any payment to the hospital until the hospital sends you a letter with its decision on your application.

Please send completed form and attachments to:
 Financial Investigation Department
 Jamaica Hospital Medical Center
 90-28 Van Wyck Expressway, 2nd Floor
 Richmond Hill, NY 11418