



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- _____.

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
Jamaica, NY 11418**



Date: ____/____/____

Patient/Guarantor Name and Address:

RE: Medical Record Number: _____

Dear

Thank you for choosing Jamaica Hospital Medical Center for your healthcare needs. We have reviewed your application for financial assistance received on ____/____/____. Based on the information provided, you do not qualify for assistance under the financial aid policy of the hospital. However, you may qualify for extended payment terms. Please contact our credit and collection department at (718) 206-6845 to make arrangements or if you have any questions.

Financial aid is based solely on financial necessity. Jamaica Hospital Medical Center does offer an appeals process **for extenuating financial circumstances that fall outside of the established financial aid criteria.**

All appeals must be submitted in writing within one month of the date of this letter. Please include a detailed explanation, along with any supporting documentation, that explains the financial circumstances not considered in the initial financial aid application process. Notification of determination will be sent no later than six weeks following receipt of the appeal. Please forward all appeals to:

Jamaica Hospital Medical Center
Attention: Director of Patient Financial Investigation Department
Financial Aid Appeals
90-28 Van Wyck Expressway, 2nd Floor,
Jamaica, New York 11418

What if I have a problem I cannot resolve with the hospital?

You may call the New York State Department of Health complaint hotline at 1-800-804-5447.

Very Truly Yours,

Financial Representative



Date:

Patient Name: _____

Account No.: _____ Date of Service: _____

Dear _____,

Once again, we thank for choosing Jamaica Hospital Medical Center for your healthcare needs. We have reviewed your appeal respective to financial assistance on _____. Based on this review, your appeal has been _____.

Please contact _____ at (718) _____ for further details on this decision.

Yours truly,

Financial Representative