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 718-670-5588 or 718-670-5589.

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
Flushing Hospital Medical Center
14601 45th Avenue, 6th Floor
Suite 600
Flushing, NY 11355