FINANCIAL HARDSHIP APPLICATION

PATIENT INFORMATION:

Applicant's Name	Social Security Number	DOB: Mo - Day - Year
Patient's Address	City, State & Zip Code	
Phone Number	Mobile Number	Email Address

PLEASE SELECT THE FACILITY THAT THE PATIENT HAS THE OUTSTANDING BALANCE WITH:

- ☐ Sight Medical Doctors of NY — Account Number: _____
- ☐ Long Island Ambulatory Center — Account Number: _____

Sometimes proper medical care may seem out of reach due to financial difficulties. We believe that there is nothing more precious than your eyesight. Ultimately, our desire is to help all of our patients achieve excellent eyesight, prevent diseases of the eye, and make exceptional treatment available to all those who need it. If you are currently experiencing hardship please complete this Financial Hardship application.

SELECT ALL THAT APPLY:

- ☐ Bankruptcy
- ☐ Unemployed
- ☐ No Insurance
- ☐ Sick Spouse
- ☐ Student
- ☐ Dependent of family for support
- ☐ Large Medical Expenses
- ☐ Social Security Only
- ☐ Retired or Fixed Income
- ☐ Other (Please describe below)

Please describe your current financial circumstance so that we can make suitable adjustments to your bill. Your application and supporting documentation will be kept strictly confidential.

Household Size: List the ***dependents*** who reside within the applicant's household. Select the appropriate box for each dependent.

Name	Age	Relationship

		Spouse	Parent	Child	Other
1. _____	_____	☐			
2. _____	_____		☐		
3. _____	_____			☐	
4. _____	_____				☐
5. _____	_____				

Total Gross Household Income (last 30 days): Please provide copies of checks, paystubs or statements to support all reported income. An application is **NOT** considered complete until all required documentation is received. Please note that an incomplete application **WILL NOT** be reviewed. **All sections of this application must be filled out.**

Source of Income	Patient	Guarantor/ Spouse
Wages	$	$
Social Security Payments	$	$
Unemployment Compensation	$	$
Disability Payments	$	$
Workers Compensation	$	$
Alimony/ Child Support	$	$
Other (describe)	$	$

The following documents are required in order to process your Financial Hardship application. These documents will be retained for our records and **WILL NOT** be shared with anyone. **Please supply copies only. Do Not mail originals.**

1) A copy your tax return (for the past year).

2) Current pay stubs (for the past 30 days).

3) Social Security Income Statement.

4) 1099 Form or current Unemployment Compensation Statement, if applicable.

5) Pension Income, if applicable.

6) Workers Compensation, if applicable.

7) Child Support, if applicable.

8) Bankruptcy Documentation, if applicable.

I attest that the information I have submitted, concerning my annual household income and family size, is accurate. I also understand that this information is subject to verification. If this information is determined to be false, such determination will result in a denial of financial assistance. If we determine that you are NOT eligible for Financial Assistance under our guidelines, you will be re-billed and will be responsible to pay the full amount of your bill for the services provided to you.

X_____ _____

Applicant / Patient Signature (Parent / Legal Guardian for minor child) DATE SIGNED

X_____ _____

Reviewed by: DATE SIGNED