Financial Aid Application

Patient Account #: _____ Medical Record #: _____

Patient's Name_____,_____ Date of Birth: _____/_____/_____
Last Name First Name Initial Month Day Year

Address_____Phone#:_____
Number, Street & Apt. # City State Zip Code

Employer Name: _____ Employer Address:_____

Telephone #: _____ Occupation: _____ Email address: _____

Income: List combined income for you, your spouse, and all other household members from:

Gross Monthly Income Source	Patient Income	Spouse Income
Employment Wages/ Self Employment		
Unemployment compensation		
Social Security Benefits		
Pension		
Disability / Workers Compensation		
Alimony/Child Support		
Dividends/interest/rentals		
All other income		
Total		

As a condition of providing financial aid, you are required to submit proof of income/resources: i.e.: 1) Paystubs.
2) Other requested documentation to substantiate household income

Family Size: _____ List family members living in your household:

NAME	AGE	RELATIONSHIP
1.		
2.		
3.		

*NOTE: Please attach another sheet, if additional space is needed

I hereby understand that the information which I submit concerning my gross 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 for Financial Aid and I will be held liable for all charges for services provided. If an approval was received based on the same information, the eligibility determination will be revoked and I will be responsible for all charges for all services provided.

I affirm that the above information is true, complete, and correct to the best of my knowledge. Further, I hereby give my permission to The Brookdale Hospital Medical Center to verify any information pertinent to this application.

Signature of Applicant: _____Date_____

Print Name: _____

If you have questions or need help completing this application, call the Financial Office at (718) 240 - 5240.
If you have received a bill or bills from the hospital, check here: ____ You may disregard any bills until the Hospital has rendered a decision on the application.

Please send completed form and attachments to: Financial Investigations