NEW YORK
PROTON CENTER

# APPENDIX A - Financial Assistance Application Form

*Please fill out all information completely. If it does not apply, write "NA." Attach additional pages if needed.*

| SCREENING INFORMATION |
|---|
| Do you need an interpreter? □ **Yes** □ **No** *If Yes, list preferred language:* |
| Has the patient applied for Medicaid? □ **Yes** □ **No** *May be required to apply before being considered for financial assistance* |
| Does the patient receive state public services such as TANF, Basic Food, or WIC? □ **Yes** □ **No** |
| Is the patient currently homeless? □ **Yes** □ **No** |
| Is the patient's medical care need related to a car accident or work injury? □ **Yes** □ **No** |

**PLEASE NOTE**

- We cannot guarantee that you will qualify for financial assistance, even if you apply.
- Once you send in your application, we may check all the information and may ask for additional information or proof of income.
- Within 30 calendar days after we receive your completed application and documentation, we will notify you if you qualify for assistance.

**PATIENT AND APPLICANT INFORMATION**

| Patient first name | Patient middle name | | Patient last name |
|---|---|---|---|
| □ Male □ Female<br>□ Other (may specify_____) | Birth Date | | Patient Social Security Number*<br>**see note on page 1 regarding Social Security Number* |
| Person Responsible for Paying Bill | Relationship to Patient | Birth Date | Social Security Number*<br>**see note on page 1 regarding Social Security Number* |

Employment status of person responsible for paying bill

□ **Employed** (date of hire:_____) □ **Unemployed** (how long unemployed:_____)

□ **Self-Employed** □ **Student** □ **Disabled** □ **Retired** □ **Other** (_____)

| Mailing Address | Permanent Address (if different than the Mailing Address) |
|---|---|
| _____ | _____ |
| _____ | _____ |
| City State Zip Code | City State Zip Code |
| _____ | _____ |
| Country | Country |

Contact Information

Email Address: _____

Main contact number(s):

**Home** ( )_____ **Mobile** ( )_____ **Work** ( ) _____

NEW YORK
PROTON CENTER

Residency Information

*Financial Assistance is limited to residents of New York State defined by NYPC policy, but nonresidents may qualify for other programs or financial support.*

How long have you lived in New York State? _____

How long do you plan to live in New York State? _____

If you have lived in NY for less than 1 year, why did you come to the state?

_____

_____

_____

_____

## FAMILY INFORMATION

List family members in your household, including you. "Family" includes people related by birth, marriage, or adoption who live together.

**FAMILY SIZE_____** *Attach additional page if needed*

| Name | Date of Birth | Relationship to Patient | If 18 years old or older: Employer(s) name or source of income | If 18 years old or older: Total gross monthly income (before taxes): | Also applying for financial assistance? |
|---|---|---|---|---|---|
| | | | | | Yes / No |
| | | | | | Yes / No |
| | | | | | Yes / No |
| | | | | | Yes / No |

**All adult family members' income must be disclosed. Sources of income include, for example:**

- Wages - Unemployment - Self-employment - Worker's compensation - Disability - SSI
- Child/spousal support - Work study programs (students) - Pension - Retirement account distributions
- Other (*please explain*_____*)*

## INCOME INFORMATION

***REMEMBER**: You must include proof of income with your application.*

**You must provide income for family members listed above. Income verification is required to determine financial assistance.**

**All family members 18 years old or older must disclose their income. If you cannot provide documentation, you may submit a written signed statement describing your income. Please provide proof for every identified source of income.**

**Examples of proof of income include:**

- A "W-2" withholding statement; or
- Current pay stubs (*3 months*); or
- Last year's income tax return, including schedules if applicable; or
- Written, signed statements from employers or others; or
- Approval/denial of eligibility for Medicaid and/or state-funded medical assistance; or
- Approval/denial of eligibility for unemployment compensation.

If you have no proof of income or no income, please attach an additional page with an explanation.

NEW YORK
PROTON CENTER

## EXPENSE INFORMATION

*We use this information to get a more complete picture of your financial situation.*

Monthly Household Expenses:

Rent/mortgage $_____ Medical expenses $_____

Insurance Premiums $_____ Utilities $_____

Other Debt/Expenses $_____(*child support, loans, medications, other*)

## ASSET INFORMATION

*This information may be used if your income is above 400% of the Federal Poverty Guidelines.*

Current checking account balance
$_____

Current savings account balance
$_____

Does your family have these other assets?
**Please check all that apply and provide supporting documentation**

□ Stocks □ Bonds □ 401K □ Health Savings Account(s) □ Trust(s)
□ Property (excluding primary residence) □ Own a business

## ADDITIONAL INFORMATION

Please attach an additional page if there is other information about your current financial situation that you would like us to know, such as a financial hardship, excessive medical expenses, seasonal or temporary income, or personal loss.

## PATIENT AGREEMENT

I understand that NYPC may verify information by reviewing credit information and obtaining information from other sources to assist in determining eligibility for financial assistance or payment plans.

I affirm that the above information is true and correct to the best of my knowledge. I understand if the financial information I give is determined to be false, the result may be denial of financial assistance, and I may be responsible for and expected to pay for services provided.

_____ _____

Signature of Person Applying Date