NEW YORK
PROTON CENTER

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 □ Other (may specify_____)	Birth Date	Patient Social Security Number* **see note on page 1 regarding Social Security Number*

Person Responsible for Paying Bill	Relationship to Patient	Birth Date	Social Security Number* **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 _____ Country	_____ _____ City State Zip Code _____ Country

Contact Information

Email Address: _____

Main contact number(s):

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

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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:

- Proof of address;
- Proof of Identity;
- Proof of income as evidenced by their most recently filed Federal Income Tax Return, or if one is not available, through other income verification (wages, disability benefits, compensation benefits, etc. by providing 30 days most recent payroll stubs or employment letter, verification of social security or unemployment benefits, or New York State Self-Attestation Form (MAP 250a));
- Proof of dependents (if claimed); and
- Proof of child support, alimony (if claimed).

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

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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