

Financial Assistance Application

https://www.stonybrookmedicine.edu/patientcare/billinginformation

31 Research Way East, Setauket NY 11733-911 (631) 444-4151 FAX (631)-444-5820

You may be eligible for financial assistance. Please complete this application as well as provide the attached necessary documents and return via mail to: Stony Brook Hospital Financial Assistance Dept.

Name of Applicant:	31 Research Way, East Setauket, N supporting documentation to (63		•	applications ca	an be fa	axed alon	ig with the
Applicant's Phone Number	Name of Applicant:	Date of Birth:			/	/	
Insurance Information (If any). Name of Insurance Company Policy Holder: Address: ID # Total Household Size: List the dependents who reside in the applicant's house for which the applicant takes financial responsibility. If more than 4 dependents, please add them to the back of this form. Name	Applicant Mailing Address:						
Name of Insurance Company Policy Holder:	Applicant's Phone Number						
Address:	Insurance Information (If any).						
Total Household Size: List the dependents who reside in the applicant's house for which the applicant takes financial responsibility. If more than 4 dependents, please add them to the back of this form. Name Date of Birth Relationship 1.	Name of Insurance Company			Policy H	lolder:		
takes financial responsibility. If more than 4 dependents, please add them to the back of this form. Name Date of Birth Relationship 1.	Address:				I	D#	
1. 2. 3. 4. Total Gross: Weekly/ Bi weekly /Monthly Income. Source of Income Applicant Income Spouse Income Wages Social Security 1099 Form Unemployment Compensation Workers Compensation Alimony / Child Support	•						
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1099 Form Unemployment Compensation Workers Compensation Alimony / Child Support	Wages						
Unemployment Compensation Workers Compensation Alimony / Child Support	Social Security						
Workers Compensation Alimony / Child Support	1099 Form						
Alimony / Child Support	Unemployment Compensation						
	Workers Compensation						
	Alimony / Child Support						
Signature of patient / Responsible Party Date	Signature of patient / Responsible	Party					