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. 31 Research Way, East Setauket, NY 11733. Completed applications can be faxed along with the supporting documentation to (631) 444-5820.

Name of Applicant: ________________________________ Date of Birth: ____ /_____ /_______

Applicant Mailing Address: ____

Applicant's Phone Number ____

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	Date of Birth	Relationship
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		

____________________________________ ______________

Signature of patient / Responsible Party Date

Last Revised 1/25/2023.