



**D. Available Assets**

(1) **Checking Account Balance:** \$ \_\_\_\_\_ **Savings Account Balance:** \$ \_\_\_\_\_

A copy of last month's bank statement must be submitted.

(2) **Value of Investments**

**Stocks:** \$ \_\_\_\_\_ **Bonds:** \$ \_\_\_\_\_ **Other:** \$ \_\_\_\_\_

A copy of your most recent investment statement must be submitted.

(3) **Health Savings Account (Flexible Spending Account)**

Annual Elected Withhold Amount: \$ \_\_\_\_\_ Balance Remaining: \$ \_\_\_\_\_

**E. Public Assistance Information**

(1) Have you applied for Medicaid, Child Health Plus, or Family Health Plus?

YES  NO  Date of application: \_\_\_/\_\_\_/\_\_\_

If Approved, what was the effective date? \_\_\_/\_\_\_/\_\_\_

If Denied, please submit a copy of the denial letter

(2) Have you applied for SSI (Social Security Income)?

YES  NO  Date of application: \_\_\_/\_\_\_/\_\_\_

If Approved, what was the effective date? \_\_\_/\_\_\_/\_\_\_

If Denied, please submit a copy of the denial letter

**F. Any other circumstance(s) you feel may qualify you for Financial Assistance:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**G. Applicant Statement:**

I certify that the above information is complete and correct. I understand that the information, which I submit, is subject to verification by Hospital for Special Surgery and subject to review. Further, I will take all steps necessary to apply for any assistance (Medicaid, Medicare, Insurance, etc.) which may be available for payment of my hospital charge. I will take any action reasonably necessary to obtain such assistance and will assign or pay the hospital the amount recovered for hospital charges. I understand that if any of the information I have given proves to be incomplete or untrue, the hospital may re-evaluate my financial status and take whatever action it deems appropriate. If my ability to pay changes significantly subsequent to the date services are rendered, I will inform the hospital.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date

*Please call (212)-606-1505 if you have any questions.*

**Please send completed Application to:**

**Hospital for Special Surgery  
Financial Assistance Program (ERP Level B)  
535 East 70<sup>th</sup> Street  
New York, NY 10021**