HSS ASC of Manhattan

Application Instructions

The HSS ASC of Manhattan has a Financial Assistance program (FAP) for patients who are concerned about their ability to pay for their medical care. Eligibility for the program is based on your family's income, assets and needs. Financial Assistance is available to individuals with household incomes that are less than those shown below:

Family Size	Annual Family Income
1	Up to $84,420
2	Up to $113,680
3	Up to $142,940
4	Up to $172,200
5	Up to $201,460
6	Up to $230,720

The FAP application also requests the following information that the HSS ASC of Manhattan may use to verify the applicant's household income. Applicants need not provide each item below if the information is not available:

- Pay stubs from the most current available three (3) month period
- Oral or written income verification from public assistance agencies
- Flexible Spending Account or Health Care Savings Account election information and balance
- Form approving or denying unemployment compensation
- Bank account or investment statements
- SSI Benefit Statement or Benefit Determination
- Self-Attestation

When completing an application for Financial Assistance please remember the following:

- Please note that if you are currently approved for Financial Assistance by HSS, the HSS ASC of Manhattan will apply the same determination to HSS ASC of Manhattan patients.
- A request for Financial Assistance may be made at any time. An individual may make a request before, during, or after services are received, including after commencement of a collection agency action against the individual.
- An application can be completed by an individual or his or her legal guardian. If you have any questions regarding completing the Financial Assistance Application, please contact the HSS ASC of Manhattan FAP staff at 212.606.1505.
- Financial Assistance covers all services provided by the HSS ASC of Manhattan and its Covered Providers. More information can be found on our website at: https://www.hss.edu/asc
- Once we receive your completed application, you can disregard any bills/statements until you receive written notification regarding your financial assistance application
- Cosmetic, experimental, and convenience services may not be deemed medically necessary under the policy, and travel related costs are not covered by Financial Assistance.

Please mail your completed application and required documentation to:
HSS ASC of Manhattan/Financial Assistance Department (ERP Plaza Level)
535 East 70th Street
New York, NY 10021

Financial Assistance Application

HSS#_____

Patient's Name: _____
Last First Middle Initial

Address: _____
Street Apt# City State Zip Code

Date of Birth:_____/_____/_____ Marital Status:_____

Best Contact #:_____ Alternate Contact #:_____Email: _____

Contact Person:_____ Relation to Patient:_____Contact #: _____

Insurance Plan:_____ Policy #:_____Ins Tele #: _____

Clinical Service Requested: _____

List all Persons living in home and legally dependent upon you for support:
(As claimed as dependents on your income tax return)

Full Name	Age	Relationship			
		Spouse/Partner	Parent	Child	Other
1) _____	_____				
2) _____	_____				
3) _____	_____				
4) _____	_____				

If you feel that you should be considered for our Special Access program, please explain below:

Total Gross Monthly Income:

Source of Income	Household Income		Source of Income	Household Income	
	3 Months	12 Months		3 Months	12 Months
Wages	*$*	*$*	**Dividends, Interests, Rental**	*$*	*$*
Social Security	*$*	*$*	**Unemployment**	*$*	*$*

Current Checking/Savings Account Balances: $ _____

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 applicable charge. I will take any action reasonably necessary to obtain such assistance and will assign or pay the applicable provider the amount recovered for applicable 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 of this application, I will inform the hospital.

Signature Print Name

Relationship to Patient Date