Financial Assistance Application
Instructions

Hospital for Special Surgery has a Financial Assistance program 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	$95,130
2	$128,170
3	$161,210
4	$194,250
5	$227,290
6	$260,330
7	$293,370
8	$326,410

The FAP application also requests the following information that HSS 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:

- 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 FAP staff at (212) 606-1505.
- Financial Assistance covers all services provided by HSS and its Covered Providers. More information can be found on our website at: https://www.hss.edu/financial-assistance.asp
- 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:
Hospital for Special Surgery
Financial Assistance Department
535 East 70th Street
New York, NY 10021

Financial Assistance Application

HSS #: _____

Patient's Name: _____ _____ _____
Last *First* *Middle Initial*

Address: _____ _____ _____ _____ _____
Street *Apt#* *State* *City* *Zip Code*

Date of Birth: _____ **Marital Status:** _____

Best Contact #: _____ **Alternative Contact #:** _____

Email: _____

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

Insurance Plan: _____ **Policy #:** _____ **Ins. Tele #:** _____

Clinical Services Requested: _____

List all Persons living in home and legally dependent upon you for support: (As claimed as dependents on your income tax return. For relationship, choose one of the following: Spouse/Partner, Parent, Child or Other. If Other, fill in the type of relationship.)

1	Full Name:		Age:		Relationship:	Other:	
2	Full Name:		Age:		Relationship:	Other:	
3	Full Name:		Age:		Relationship:	Other:	
4	Full Name:		Age:		Relationship:	Other:	

Are you seeking care that is not reasonably available closer to your residence? _____

Are you seeking highly specialized care that is not reasonably available at other hospitals? _____

Total Gross Income:

Source of Income	Household Income 3 Months	Household Income 12 Months
Wages		
Social Security Payment		
Dividends, Interest, Rental Income		
Unemployment Compensation		

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:** _____