Traditional Chinese

Mount Sinai

地點：

MSBIB ☐	MSBI ☐	MSH NY ☐	MS NYEEI ☐
MSH Qns ☐	MSSL ☐	MSRH ☐	REAP ☐
	HEAL RH ☐	HEAL SL ☐	

醫療體系經濟援助申請

申請日期：_____ 申請者：_____

患者姓名：_____
姓 名 中間名首字母

地址：_____
街 城市 州 郵遞區號

所提供/申請的服務類型： ( ) 住院患者 ( ) 門診患者 ( ) DTC ( ) 門診手術 ( ) ED ( ) 特殊服務/轉診門診
( ) RTC/Dubin/MSBIMC 綜合癌症中心西院 MSBIMC 放射腫瘤科 ( ) 皮特里/PACC/ 羅斯福分區
服務日期：

申請者聲明：

我證明上述資訊是正確的。我理解我所遞交的資訊需要經過（**西奈山醫療體系**或其指定方）的驗證並需要經過審查。此外，我將採取所有必要步驟申請可能獲得用於支付我的醫院收費的任何援助（聯邦醫療補助[Medicaid]、聯邦醫療保險[Medicare]、保險等）。我將採取任何合理必要的行動以獲取此類援助並將收回的數額分配或支付給醫院用於醫院收費。我理解如果我給予的任何資訊被證實為非真實的，醫院可能重新評估我的經濟狀況並採取任何被視為適當的行動。我理解只要我的申請在處理之中就不需要付款並且我可以無視所有醫院的賬單。

_____ _____ _____
簽名 日期 姓名正楷

_____
關係

ELIGIBILITY DETERMINATION (For Office Use Only)

Date Application Received:_____ Patient Number: _____

Family Income:

Current Monthly Income (wkly x 4.333)	Annual Income (based on current x 12)	Family Size

Income Verified: ( ) Yes ( ) No Type of Verification: ( ) Pay Stubs ( ) Other (specify below)

_____

Family Composition Verified: ( ) Yes ( ) No

( ) The applicant is approved for a Financial Assistance discount under level ____ or F/C allocation ____.

( ) OPD/DTC visits approved at Category ( ) of the schedules.

( ) The applicant's request for Financial Assistance has been denied for the following reason(s).

_____

Date of Determination: _____ Initiated By: _____
Print Name and Sign

Authorization period _____ Reviewed/Approved By: _____
Print Name and Sign

Exception to policy reason _____ Approved by _____

Applications must be filed within 240 days from the point of service. Applications must be completed within 30 days from the point of application. If this application is denied, please follow the appeal instructions attached hereto. Denials MUST be appealed with in 30 days of the adverse decision in accordance with Part 10 of the policy.

IF YOUR APPEAL IS UNSUCCESSFUL OR, IF YOU DO NOT AGREE WITH THE DECISION; YOU MAY CONTACT THE NYS DEPARTMENT OF HEALTH AT 1-800-804-5447