Haitian Creole

Mount Sinai

SIT:

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

APLIKASYON POU ASISTANS FINANSYÈ SISTÈM SANTE

Dat Demann lan: _____ Demandè an: _____

Non Pasyan an: _____
Siyati Prenon Inisyal Dezyèm Prenon

Adrès: _____
Ri a Vil Eta Kòs postal

Kalite Sèvis yo Ofri/yo Mande: ( ) Pasyan entèn ( ) Pasyan ekstèn ( ) DTC ( ) Chiriji anbilatwa ( ) ED ( ) Sèvis Spesyal/Sèvis anbilatwa pa referans ( ) RTC/Dubin/MSBIMC Comprehensive Cancer Center West MSBIMC Radyoloji Onkoloji ( ) Petrie/PACC/ Roosevelt Division

Date Sèvis (yo):

_____

Deklarasyon Demandè a:

Mwen sètifye ke enfòmasyon ki anlè yo kòrèk. Mwen konprann enfòmasyon mwen te bay yo gendwa verifye pa (**The Mount Sinai Health System** oswa moun li deziyen yo) epi yo gendwa analize yo. Epitou, mwen pral pran tout mezi ki nesesè yo pou kapab aplike pou kèlkeswa asistans (Medicaid, Medicare, Asirans, elatriye) ki gendwa disponib pou peman bòdwo lopital mwen an. Mwen pral pran kenenpòt aksyon ki rezonabman nesesè pou jwenn asistans sa a epi mwen pral asiyen oubyen peye lopital la montan yo kolekte pou bòdwo lopital la. Mwen konprann si kèlkeswa enfòmasyon mwen te bay pa t kòrèk, lopital la gendwa re-evalye sityasyon finansyè mwen an epi mwen pral pran kèlkeswa aksyon ki sanble ki apwopriye. Mwen konprann yo p ap bezwen okenn peman epi mwen gendwa pa okipe bòdwo Lopital la voye pandan y ap trete aplikasyon mwen an.

_____ _____
Siyati Dat Ekri Non an ak Lèt Majiskil

_____
Relasyon ou ak Pasyan an

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