Patient Name: _____ **Account #:** _____

Address: _____

_____

_____

Parent Name(s): _____

Under the NYS Healthcare Financial Assistance Law, healthcare facilities are obliged to make their services available without charge or at a reduced charge to those patients whose income levels meet the established criteria and request such financial assistance. You may be eligible for such assistance.

In order for Blythedale Children's Hospital to determine your eligibility, you must complete the enclosed application and return it to the Blythedale Children's Hospital Patient Accounts Department. We will process your request and notify you within one month if any financial assistance is applicable.

In the event you choose to waive this offer, please complete the "Financial Assistance Waiver" form below.

Please contact the Patient Accounts Department at (914) 831-1786 with any questions.

FINANCIAL ASSISTANCE WAIVER

I, _____, (Parent/Guarantor) wish to decline the offer of financial assistance towards the liability incurred for services rendered to (patient name)_____.

X_____ Date: _____

Parent/Guarantor Signature

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