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

**Address:** _____

_____

_____

**Parent Name(s):** _____

Under the self-pay assistance guidelines, healthcare facilities are obliged to make a reasonable volume of their services available without charge or at a reduced charge to those patients whose income levels meet the established criteria. You may be eligible for such assistance. However, this does not apply to co-payments, deductibles or co-insurance.

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

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

Any questions, please contact the Business Office at (914) 592-7555 ext. 71478 or (914) 831-2481.

## 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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