Payment Options

Stony Brook Medicine recognizes that there are times when patients in need of care will have difficulty paying for services provided. The Financial Assistance Program provides discounts to qualifying individuals, based on income.

Q Who qualifies for a discount?
A Financial assistance is available to patients who have limited income, have no health insurance or are underinsured. You cannot be denied medically necessary care because you need financial assistance. You may apply for a discount regardless of immigration status.

Everyone in New York State who needs emergency services and non-emergency, medically necessary services at Stony Brook Medicine can receive care and may be eligible for assistance based on income limits that have been established by federal guidelines outlined below.

<table>
<thead>
<tr>
<th>Family Size</th>
<th>2020 Annual Income (at or below)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$51,520</td>
</tr>
<tr>
<td>2</td>
<td>$69,680</td>
</tr>
<tr>
<td>3</td>
<td>$87,840</td>
</tr>
<tr>
<td>4</td>
<td>$106,000</td>
</tr>
<tr>
<td>5</td>
<td>$124,160</td>
</tr>
<tr>
<td>6</td>
<td>$142,320</td>
</tr>
<tr>
<td>7</td>
<td>$160,480</td>
</tr>
<tr>
<td>8</td>
<td>$178,640</td>
</tr>
</tbody>
</table>

Q What if I do not meet the income limits?
A In addition to payment plans for those patients who meet the federal income limits listed on the left, Stony Brook Medicine extends payment plans to patients who exceed those income limits. The amount you pay depends on your income.

Q Can someone explain the discount? Can someone help me apply?
A Yes. Free confidential help is available. Call our Financial Aid Unit at (631) 444-4331. If you do not speak English, someone will help you in your own language. The financial counselor can tell you if you qualify for free or low-cost insurance, such as Medicaid, Family Health Plus and Child Health Plus.

If the counselor finds that you don’t qualify for low-cost insurance, he or she will help you apply for a discount. The counselor will help you fill out the forms and tell you what documents you need to bring.

Q How do I apply for a discount?
A A financial assistance application is available online at stonybrookmedicine.edu/billinginformation. You may also pick up an application from the cashier in the Emergency Department or the Admitting Office at any of our facilities (Stony Brook University Hospital, Stony Brook Southampton Hospital or Stony Brook Eastern Long Island Hospital).

A financial assistance application will be sent to you upon your request if you call our Financial Aid Unit at (631) 444-4331. You will need to supply copies of all requested documentation. If you cannot provide these, you may still be eligible to apply for financial assistance.

Q What happens if I receive a bill while I’m waiting to hear if I get a discount?
A You cannot be required to pay a hospital bill while your application for a discount is being considered. If your application is denied, the hospital must explain why in writing and provide you with a way to appeal this decision to a higher level within the hospital.

Q What if I have a problem that I cannot resolve with the hospital?
A You may call the New York State Department of Health Complaint Hotline at (800) 804-5447.
Dear Patient:

As per your request, attached please find an application for Financial Assistance. Please complete the attached form and return it with COPIES of the requested documentation in the enclosed stamped self-addressed envelope. Upon submission of your completed Financial Aid Application you may disregard your bills until receiving our final decision.

When you receive an approval, your current bills will be reduced. Our Business Office will then send your discounted bill(s) for which we will expect payment in full.

Sincerely,

Financial Aid Representative
(631) 444-4331

Attach.
FINANCIAL AID APPLICATION
31 Research Way
East, Setauket, NY 11733-9113
(631) 444-4331

You may be eligible for financial aid. Please complete this application and mail or bring it to the Stony Brook Medicine Business Office with the requested documentation. We will advise you of our determination within 30 days receipt of the completed application. Thank you.

Name of Applicant: ___________________ Date of Birth: ____________

Street Address of Applicant: ______________________________________

City, State, and Zip Code: ________________________________________

Names and Birth Dates of Family Members Applying: __________________
__________________________
__________________________

Home Telephone #: ________________ Cell Phone #: ________________

Insurance Information (if any)
Name of Insurance Company: ________________________________
Address: ________________________________________________

ID # and copy of the card: _______________________________________

I hereby make submit this application to Stony Brook Medicine, State University of New York at Stony Brook, for consideration under the Financial Assistance Program.

I certify that the information contained in this application is true and correct and that the documentation submitted in support of this application, as to earnings and number of dependents is true and correct.

Signature of Patient/Responsible Party ___________________________ Date _________
Dear Patient:

The following documents are requested to process your financial assistance application. *(THESE WILL BE RETAINED FOR OUR RECORDS – PLEASE SUPPLY COPIES ONLY AND BE SURE THEY ARE SIGNED).*

- Most recent Federal Income Tax (Optional).
- Current W-2 form(s).
- 1099 form or current Unemployment statement, if applicable.
- Letter of Social Security benefits, if applicable.
- Pension, if applicable.
- Workers Compensation, if applicable.
- Child Support, if applicable.
- Copies of three consecutive pay stubs or letter from employer stating wages and length of employment, if applicant is presently working.
- Letter of support showing dollar value from person claiming to provide said support *(If you are not working).*
- List of Dependents *(Including their Birth Dates).*

Sincerely,

Financial Aid Representative

PLEASE RETURN YOUR APPLICATION AS SOON AS POSSIBLE. UPON RECEIPT YOU WILL RECEIVE A WRITTEN RESPONSE IN APPROXIMATELY 30 BUSINESS DAYS.