Financial Assistance Application

https://www.stonybrookmedicine.edu/patientcare/billinginformation

31 Research Way East, Setauket, NY 11733- 9113

(631) 444-4151

FAX (631) 444-5820

You may be eligible for financial assistance. Please complete this application as well as provide the attached necessary documents and return via mail to: **Stony Brook Hospital Financial Assistance Dept.** ***31 Research Way, East Setauket, NY 11733***. Completed applications can be faxed along with the supporting documentation to (631) 444-5820.

Name of Applicant: _____ Date of Birth: ___/___/___

Address of Applicant: _____

Applicant's Phone Number ( ) _____

Insurance Information (If any).

Name of Insurance Company _____ Policy Holder: _____

Address: _____ ID # _____

Total Household Size: List the dependents who reside in the applicant's house for which the applicant takes financial responsibility. If more than 4 dependents, please add them to the back of this form.

NAME	**DATE Of BIRTH**	**RELATIONSHIP**
1		
2		
3		
4		

Total Gross: Weekly/ Bi Weekly /Monthly Income.

Sources of Income	**Applicant Income**	**Spouse Income**
Wages	$	$
Social Security Payment	$	$
1099 form or Unemployment Compensation	$	$
Disability Payment	$	$
Workers Compensation	$	$
Alimony / Child Support	$	$

_____ _____

Signature of patient / Responsible Party Date

Last Revised 10/19/2022