St Barnabas Hospital
Financial Assistance Charity Care Application

Name _____

Address _____ Place

_____ Label

Phone _____ Here

Family size / number in household _____

	Patient Income	Spouse Income
Wages		
Social Security payment		
Unemployment compensation		
Disability		
Workers compensation		
Alimony/child support		
Dividends/interest/rentals		
All other income		
Total		

I affirm that the above information is true, complete, and correct to the best of my knowledge.

Signed _____ Date _____

If you have questions or need help completing this application, **Contact our Financial Counselors Taishia Burgado or Janice Morales at (718)960-9000 extensions: 4536, 1414 or go to Room 113 in the Ambulatory Care Building or Patient and Family Service Center**

Betsy 718-960-1270

If you have received a bill or bills from the hospital, check here: ☐

Please send completed form and attachments to: St Barnabas Hospital, Financial Assistance Program, 4422 Third Avenue, Bronx, New York 10547 or bring them to SBH **Financial Counselors at Room 113 in the Ambulatory Care Building; or Patient and Family Service Center.**

Based on the information you provided, your application for Financial Assistance was:

☐ **Approved** ☐ **Not Approved**

For St. Barnabas Use

Notified Patient on Date: _____ **By:** ☐ **Mail** ☐ **Telephone** ☐ **in Person**

Register/Credit Representation: _____ **Date:** _____