NewYork-Presbyterian/Lawrence Hospital
55 Palmer Avenue
Bronxville, NY 10708

FINANCIAL ASSISTANCE PROGRAM APPLICATION

Patient Name _____ **Date of Birth:** _____

Address _____ **City** _____ **State** _____ **Zip** _____

Home Phone # _____ **Bus. Phone #** _____ **Cell#** _____

Marital Status: _____

Employer (Patient) _____

Employer (Spouse) _____

*** If patient is a minor please include employment information of parent(s).**

LIST HOUSEHOLD MEMBERS / DEPENDENTS

Name	Relationship	Age

Does anyone else claim you on their income Tax: ☐ **Yes** ☐ **No** **Who:** _____

ANNUAL INCOME Total income of all sources received by patient/spouse or parent (if minor)

	Patient	Spouse	Mother	Father
Salary (include overtime, tips, commissions, etc)	$	$	$	$
Self Employment Income				
Unemployment Income				
Social Security Income				
Disability Income				
Workers Compensation Income				
Pension/Retirement Income				
Rental/Boarder Income				
Alimony/Child Support				
Other				

CHECKING ACCOUNT(S)
Please provide a complete current copy of all checking accounts for patient, as well as spouse's, or parents' (if applicable) and return with application

I affirm by my signature below that the information contained in this application is true to the best of my knowledge. I agree to provide additional information as requested in order to determine eligibility.

_____

APPLICANT SIGNATURE **DATE**

_____

PARENT/GUARDIAN SIGNATURE **DATE**