SBH Health System
Financial Assistance Application

Name ______________________________________

Address ____________________________________

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Phone _____________________________________

Family size / number in household ______________

Place
Label
Here

	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 Cortijo or Mildred Delgado at (718)960-9000 extensions: 6830,6831 or go to Room 113 in the Ambulatory Care Building or Patient and Family Service Center**

Gloria Martinez 718-960-9000 extension: 3812

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

Please send completed form and attachments to: SBH Health System, 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 SBH Health System Use

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

Register/Credit Representation: ___________________________ **Date:** _____________