Brookhaven Heart

Clear Form

Patient Assistance Application

(Please complete, print, and sign. Do not leave blank fields)

Name: (*First, Middle, Last*)	Birth Date		Sex: ☐ M ☐ F
Social Security Number:	Marital Status: ☐ Single ☐ Married ☐ Other		
Mailing Address of Patient -Street		City	
State	Zip code	Home Phone	Cell Phone
Email:			

Financial information:

Number of people in your house hold (Include yourself, spouse and dependents) :		
Total Household Income per month: $	Total Household Income per year: $	
Occupation:	Employer:	Employer Phone:

Referral & Contact/s Information

Primary care Physician	Referring Physician	
Previous Cardiologist	Address	Phone
Pharmacy	Address	Phone
Next of Kin and/or Healthcare Proxy	Relationship	Phone
How did you find us: ☐ Friend ☐ Relative ☐ Doctor ☐ Internet ☐ Advertisement ☐ Insurance book ☐ Other		

Insurance Information

Do you have health insurance (Check all that apply) ☐ Medicaid ☐ Medicare A or B ☐ Private Insurance ☐ Other (specify) None ☐		
Mailing Address of Insurance company	State	Zip code
Policy number	Group number	

Please go to next page>>

Main office: 325 East Main Street, Patchogue, New York 11772. P (631) 654 3278. F (631) 654 1474
915 Hillside Ave, New Hyde Park, New York 11040 P (516) 358 8100. F (631) 654 1474
www.brookhavenheart.com

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(Please complete, print, and sign. Do not leave blank fields)

By signing below, I promise that:

- All of the information I provided in this sign-up form and the copies of the income documents or other information about me that I may provide is complete and true.
- If I am approved to get temporary cardiac care, I will not try to get reimbursed for the free care from anyone else, including from an insurance program or any other charity.
- If my insurance coverage changes in any way, I will immediately notify Brookhaven Heart PLLC

I give my permission to:

Brookhaven Heart PLLC and any companies that Brookhaven Heart PLLC uses to administer the program (its Administrators) to use my information, and share it with my healthcare providers, my insurance company, and other organizations or companies that might be able to help me, so that Brookhaven Heart PLLC and its Administrators may:

- Decide if I am eligible for this program,
- Help me enroll (if I am eligible) and help get the free temporary cardiac care, and find out whether I may be eligible for, or am already enrolled in, another program (including a insurance plan or another charitable program).
- My insurance company and healthcare providers and others who may be helping me apply to this program to share information about me with Brookhaven Heart PLLC and its Administrators.

I understand that:

- I have to send my most recent Federal Tax Return or other proof of income for reviewing this application. Brookhaven Heart PLLC and its Administrators may ask for additional documents and information at any time, even if I am already enrolled, so that they can decide if the information on this sign-up form is complete and true.
- Brookhaven Heart PLLC and its Administrators will only ask for the information that is needed to process my signup form, to help me with free temporary cardiac care if I am enrolled.
- If there is missing information on my sign-up form, if I have not provided the right income documents, or if I do not respond to requests for additional documents or information, Brookhaven Heart PLLC and its Administrators can delay my enrollment, decide I am not eligible, or stop providing me with temporary free care.
- Brookhaven Heart PLLC and its Administrators will only share my information as described on this form or as required or allowed by law.
- If I am enrolled, Brookhaven Heart PLLC will only give me free temporary cardiac care for a short time and I will have make arrangement for further cardiac care through elsewhere or our organization by following our financial policies.
- I have the right to revoke my promises and permissions at any time by writing to the Brookhaven Heart PLLC at the address in this sign-up form.
- If I revoke my promises and permissions, I will no longer be eligible for this program and my enrollment will end.
- I may not be eligible for free care if I have health insurance coverage that will pay for my cardiac care
- This program may be changed or stopped at any time without notice.

- **If the patient is 18 years of age or older**, the patient must sign and date the form.
- **If the patient is 18 years of age or older and incapable of signing**, legally authorized substitute may sign and date the form. Please indicate your legal authority and include documentation of your relationship

Legal Guardian Health care agent

Signature	**Date Signed**

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