Post-Discharge Assistance

Pursuant to Law Dept. Policy L-6

[Hospital Name]

I am a patient at ____ ("Hospital"). My doctor, or other health care provider, has recommended that when I leave the Hospital, I will need:

____

____ ("Service").

I am not able to pay for the Service and I have no other resources. The Hospital can pay for the Service for me so that I can safely be discharged from the Hospital. But this is the ***only time*** the Hospital can/will pay for the Service – ***the Hospital cannot pay for the Service another time***.

I acknowledge that the Hospital can only pay for the Service this one time.

Patient Signature:______________________________ Date:___________

Patient printed name: ________________________________