STAMFORD HEALTH

Financial Assistance Application
*(Application Must Be **COMPLETELY** Filled Out)*

Date of Request: ____/____/_____

Patient information:
Last name: _____ First Name _____Middle Initial ____

Date of Birth: _____/_____/_____ Social Security Number: _____

Address: _____ Apt # _____

City: _____ State: _____ Zip code: _____

Home Telephone# (____) _____ Other Telephone# (____) _____

Dependents in household:

	Name	Date of Birth	Relationship to Patient
1.			
2.			
3.			
4.			
5.			

Income Information:

Income	Patient	Spouse
Employer		
Gross Wages		
Child Support/Alimony Received		
Pension		
Unemployment Benefits		
Social Security Benefits		
Rental Income		
Other Income		
Food Stamps		
Total Income		

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Please provide copies of available documents on the attached list of Documentation and Verification Forms. Patients are to provide this information within 15 days of receiving the application. You can mail or drop off your documents. The address is provided below. All information provided, discussed, or recorded in relation to this application is confidential. If you have questions or require further assistance, contact a Financial Assistance Counselor at (203) 276-7515 or (203) 276-4831 at the Patient Business Department.

Mailing Address:
Stamford Health
One Hospital Plaza
PO Box 9317
Stamford, CT 06904

Physical Address:
Stamford Health
One Hospital Plaza
Stamford, CT 06902

Additional information that the applicant wishes to be taken into consideration:

_____

_____

_____

I hereby request financial assistance from Stamford Hospital, including access to hospital bed funds that may be available and for which I may be eligible. I understand that the information which I have submitted is subjected to verification by Stamford Hospital. I certify that the above information is true and correct. I understand that I may be asked to apply for public assistance, if eligible.

Applicant's Signature: _____ Date:_____

Please note that failure to complete this application and provide the information requested within the time allotted will delay processing of your request and may result in a determination that you are not eligible for financial assistance.

FOR HOSPITAL USE ONLY

MR#: _____

Family Size#_____

Financial Assistance Level Approved: _____@_____%

FAP Approved: From: _____To: _____

Prenatal Approved: From: _____To: _____

Denied Date: _____

Reason for Denial: _____

By FC: _____ Date: _____

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Documentation and Verification Forms

Please provide applicable documents listed below for applicant/spouse and children (if applicant is a minor provide parents information) to your Financial Assistance Counselor or the Patient Business Services Department.

PLEASE PROVIDE US WITH COPIES OF THE FOLLOWING DOCUMENTATION

Insurance:

Health □ YES or □ NO Liability □ YES or □ NO
Workers' comp □ YES or □ NO MVA □ YES or □ NO
Have you applied for insurance coverage with Access Health CT □ YES or □ NO

ALL INFORMATION REQUESTED IS FOR PATIENT, SPOUSE, AND CHILDREN IN THE HOUSEHOLD.

Federal and State Benefits:

□ Department of Social Services Denial Letter
□ Food Stamps/Cash Assistance Letter
□ Department of Social Services Medical (Medicaid) coverage
□ Social Security Benefits Letter

Identification:

□ Photo ID / Driver's license/ Passport / Permanent Resident Card
□ Proof of Current Address (utility bills, cable, telephone)
□ Children's Birth Certificate

Income: wages, salaries, tips, and dividends

□ Most Recent Pay Stubs (4 if paid weekly / 2 if paid bi-weekly and 2 if paid monthly)
□ Letter from employer or self is needed if paid via cash or personal check
□ Unemployment payment History (if collecting unemployment)
□ If unemployed, please provide a letter indicating how you support yourself.
□ Alimony and/or Child Support (Court document or a letter indicating amount received)
□ Do you own Property other than the primary residence?
□ YES or □ NO if yes, rental income $_____

Taxes:

□ Most Recent Filed Tax Return and W-2 or 1099

Banking:

□ Most recent Bank Account Statements for patient and spouse (Checking's, Savings)
□ YES or □ NO If no, please initial _____

Residence Information:

□ Rent Receipt / Lease or Mortgage Statement
□ Letter from landlord or self (amount you pay for rent each month)
□ Shelter letter