

HOSPITAL FOR SPECIAL CARE FINANCIAL ASSISTANCE APPLICATION

Name _____ Telephone _____

Address _____

HOUSEHOLD MEMBERS (LIST YOURSELF FIRST)

Name(s)	Relation	Sex	Date of Birth	Birthplace	Social Security #
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

If you or any member of the household is pregnant, list name _____ and due date _____

Are you a U.S. Citizen? ____ Yes ____ No If no, Give Alien Status _____ and number _____

U.S. Entry Date _____ Place of Entry _____ and Country of Origin _____

EMPLOYMENT INFORMATION

Please list the present or last employer for you and anyone else earning income in your household.

Name	Employer	Position	Hire Date	End Date	Reason for Leaving
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

CURRENT INCOME

Wage Earner Name	Employer	Hours/Wk	(Circle One) Amt. (Per Month/Week) (Gross)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

OTHER INCOME	YES	NO	Date Applied	Amt. Per Mo/Wk (Gross)
SSI	___	___	_____	\$ _____
Social Security	___	___	_____	\$ _____
Pension	___	___	_____	\$ _____
Annuities	___	___	_____	\$ _____
Worker's Compensation	___	___	_____	\$ _____
Unemployment Compensation	___	___	_____	\$ _____
Veteran's Benefits	___	___	_____	\$ _____
Military Allotment	___	___	_____	\$ _____
Sick/Disability Benefits	___	___	_____	\$ _____
Boarder/Roomer Income	___	___	_____	\$ _____
Rental Property Income	___	___	_____	\$ _____
Child Support/Alimony	___	___	_____	\$ _____
Other (type & source)	___	___	_____	\$ _____

If you have no income, please explain how you have been meeting your medical/basic living needs.

ASSETS

Do you or anyone in your household have any of the following?

Cash on Hand _____ Yes _____ No _____ If yes, amount \$ _____

Bank or Credit Union Accounts _____ Yes _____ No If yes, complete below:

Name of Bank/Credit Union	Address	Account #	Type	Balance
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____

Annuities, Trusts and/or Stocks & Bonds Yes No **If Yes, complete below:**

Name of Company/Institution	Account Number	Number of Shares	Current Value
_____	_____	_____	_____
_____	_____	_____	_____

Motor Vehicle(s) cars motorcycles, trailers, campers, boats, etc. Yes No

Type	Make	Model Year	Registration #	NADA Value	Loan Balance	Equity
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

Life Insurance: Yes No **If Yes, complete below:**

Insured	Company Name	Effective Date	Face Value	Cash Value
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Real Property: Yes No **If Yes, complete below:**

(House, Land, Rental Property, etc.)

Location and Type of Property	Mortgage Holder	Current Loan Balance
_____	_____	_____
_____	_____	_____

Other Assets: Yes No **If Yes, please explain:** _____

MILITARY HISTORY

Have you or anyone else in your Household served in the military? Yes No

If Yes, Name: _____ Dates of Service: _____

Branch of Service: _____ Disabled Veteran: Yes No

Applied to: Sailor, Soldier, Marine Fund: Yes No If Yes, date of application: _____

Applied to: Veterans' Administration: Yes No If Yes, date of application: _____

MEDICAL INSURANCE/BENEFITS

Person Covered	Source & Type (ie., Insurance Carrier/HMO)	ID/Case Number	Effective Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

EXPENSES

<i>RENT</i>	Monthly/Weekly	<i>OWNED PROPERTY</i>	Monthly/Weekly
Apartment/House	\$ _____	House	\$ _____
Room and Board	\$ _____	Condominium	\$ _____
Room Only	\$ _____	Mobile Home	\$ _____
Other (explain)	\$ _____	Other (explain)	\$ _____
Rent includes (please check)		Mortgage Expense	\$ _____
Hot Water ___ Heat ___ Electric ___ Gas ___		Yearly Taxes	\$ _____

UTILITY EXPENSE

Heat/Electric/Gas	\$ _____
Telephone	\$ _____
Cable TV	\$ _____
Water	\$ _____

CREDIT CARD DEBT

Creditor	Monthly Payment
_____	\$ _____
_____	\$ _____
_____	\$ _____

OTHER MISCELLANEOUS HOUSEHOLD EXPENSES

(CIRCLE ONE)

Child Support/Alimony	\$ _____	weekly/monthly/yearly
Car/Vehicle Loan	\$ _____	weekly/monthly/yearly
Car/Vehicle Insurance	\$ _____	weekly/monthly/yearly
Health Insurance	\$ _____	weekly/monthly/yearly
Life Insurance	\$ _____	weekly/monthly/yearly
Tuition/Student Loan	\$ _____	weekly/monthly/yearly
Hospital/Physician Expense	\$ _____	weekly/monthly/yearly
Child Care	\$ _____	weekly/monthly/yearly
Personal Loan	\$ _____	weekly/monthly/yearly
Other (list)	\$ _____	weekly/monthly/yearly
	\$ _____	weekly/monthly/yearly

APPLICANT

RIGHTS AND RESPONSIBILITIES

1. I hereby request Charity Care from Hospital for Special Care.
2. I certify that all statements made by me on this application are true and correct, under penalty for false statement, as provided by the Hospital for Special Care's Charity Care Policy.
3. I understand that I have a right to appeal if I am dissatisfied with the Hospital's decision on my application.
4. I agree that the information provided by me on this application must be verified; and I agree to provide documentation as requested.
5. I authorize Hospital for Special Care to conduct an investigation to establish my eligibility, and give the hospital permission to obtain personal and/or financial information necessary from, but not limited to, the following sources: banks, credit unions and other financial institutions, employers, medical providers, landlord, credit agencies, and other State and federal agencies such as the Department of Social Services, the Department of Labor, the Social Security Administration, Department of Veterans Affairs, and the Immigration and Naturalization Service.
6. I agree to complete the application process for any Third Party Benefits for which I may be eligible, including Health Insurance, Veterans Benefits, etc. Further, I agree to apply for and complete the application process for State Medical Aid and/or Town Medical Aid.

Signature of applicant

Date

Signature of Spouse/Interpreter/Witness

Date

Signature of Patient Account Representative

Date

MAIL TO: Hospital for Special Care, 2150 Corbin Avenue, New Britain, CT 06053
Attn: Patient Account Representative



We Rebuild Lives.

Hospital for Special Care
Appeal of Eligibility Determination for Charity Care

Patient or Guarantor Name

Address

City, State, Zip Code

The Charity Care decision was received on _____.

Check one:

_____ I am appealing the decision of **denial** of Charity Care.

_____ I am appealing the decision of the **percentage** that was approved.

Based on the following information, please reconsider my application for Charity Care based on the following:

Please attach any documents that support the above information.

Signature

Date

Hospital for Special Care
Charity Care Worksheet

Patient Name _____ Request Date _____

Address _____ Determination Date _____

_____ Valid Until _____

Family Size _____

Monthly _____

Yearly _____

Denial Reason:

Over Income: _____

Requested Information
Not Provided: _____

Significant Assets: _____

Income Verification Provided (attach copies)

Assets

Assets Verification Provided (attach copies)

Income Limits

Eligibility

Yes _____
% _____
No _____

Recommendation/Notes

Total _____

Reviewed by _____ Date _____

Approved by _____ Date _____

Denied by _____ Date _____

