Middlesex Health

Instructions for Completing the Middlesex Health Financial Assistance Application

For your convenience, check each box as the item is obtained and/or completed
Please return this form with your application

****************************ALL APPLICANTS* ******************************

☐ ALL application questions are answered completely. If the question does not apply to you, write NA (not applicable) or NONE on each line
☐ Sign and date the Application and Authorization Notice

You must provide the following documents with the application:

☐ Photo ID (driver's license, Passport, Immigration ID Card)
☐ Non-residents or Undocumented Visitors must provide proof of entry into the United States
☐ Proof of GROSS WAGES → Attach your last 13 weeks of wages beginning with the date you signed the application (i.e. pay stubs, last pay stub with year-to-date gross wages, signed statement from employer with gross wages
☐ Other Monthly Income → Attach 13 weeks beginning with the date you signed the application (i.e. rental, pensions/annuities, child support)
☐ Complete copy of most recent Income Tax Return
☐ Check the box if you and/or your spouse have not filed an income tax return in the last 3 years
☐ Direct Deposit of Income → Attach most current 3 months of your bank statements showing direct deposit (i.e. social security)
☐ 3 most current months of all bank statements, all pages must be included

Note: all deposits listed on bank statements are considered income unless supporting documentation can be supplied indicating deposits are a loan (example of supporting documentation: a loan agreement)

****************************IF SELF EMPLOYED******************************

☐ If you are Self Employed → Submit 13 weeks of your gross business income & business expenses from your business ledger, quarterly statement provided to accountant, or on business stationery signed & dated

Name and Address of your Business:_____

************************STATE ASSISTANCE APPLICATIONS ************************

(checking this box does not affect your ability to receive sliding scale discounts)

☐ If you have applied for state assistance, provide us with the eligibility or denial letter received from the State of Connecticut, Department of Social Services

****************************EXTENSION REQUESTED******************************

If you are not able to return the application and all required documents within the stated time frame, but still wish to complete the application process, please call our office to obtain a 10-day extension:

- **Dial (860) 358-2402, Press 2**
- Speak clearly and slowly and leave your NAME, PHONE NUMBER, & ACCOUNT NUMBER, if available
- Press 0 and hang up.

You will be granted a 10 day extension from the date of your call. This is an automated process so you will not receive a return call unless we need to clarify your phone message. If the information is not received within 10 days your application will be denied. Once denied, if you wish to re-apply, you will need to request a new application.

If you need assistance completing the application or have questions, please call: **(860) 358-2402, Press 1**

Middlesex Health

FREE BED FUNDS AND OTHER FINANCIAL ASSISTANCE PROGRAMS

Federal and state laws require all hospitals to seek payment for care provided. Therefore, it is important that you let us know if there may be a potential problem paying your bill. If you do not have health insurance or worry that you may not be able to pay for part or all of your care, we may be able to help. Middlesex Health provides financial aid to hospital patients based on their income, assets and financial needs. In addition, we may be able to help you get free or low-cost health insurance or work with you to arrange a manageable payment plan. In most cases, financial assistance for the free bed funds and other financial assistance programs are based on a sliding scale that considers your income and the number of dependents in your family as described in the chart below.

- **Free Bed Funds:**
  The free bed funds originate from gifts made to Middlesex Health. The interest earned on these funds enables the hospital to provide some services at no cost or at a reduced cost. In general, you will not receive such funds if you do not meet the income guidelines set forth in the chart below. There may also be specific requirements relating to a particular bed fund. If you are denied financial assistance from the free bed funds, you may reapply. Additional bed funds may become available on an annual basis.

- **Other Financial Assistance:**
  In addition, Middlesex Health provides other financial assistance programs. Qualifications for these financial assistance programs are based in general on the income guidelines set forth in the chart below, but without the restrictions that may be imposed by the free bed funds. These financial assistance programs are maintained and administered separately from the free bed funds. If financial assistance is denied, you may reapply at a later date.

To apply for either free bed funds or other financial assistance programs, please call 860-358-2402 or 860-358-2403 to speak with a Financial Counselor or visit us at the Middlesex Health Outpatient Center, 534 Saybrook Rd., Middletown, CT 06457. We will treat your questions and any information you provide with confidentiality and courtesy.

Household Size	**Gross Household Income Effective Date 02/01/2023**
#	AT OR BELOW:
1	$72,900
2	$98,600
3	$124,300
4	$150,000
5	$175,700
6	$201,400
7	$227,100
8	$252,800
For more dependents, add to income for each additional member: $25,700	

Middlesex Health

APPLICATION FOR FINANCIAL ASSISTANCE

Applicant Name:	**Date of Request:** **Completed application due back within 12 days from request date**
Medical Record Number (MRN):	
Address:	**Phone**:
	Cell:
Spouse/Domestic Partner Name:	**Email**:
US Citizen *(optional)*: ☐ Yes ☐ No	**If Yes to U.S. Citizen, State of Residence:**

HOUSEHOLD INFORMATION

Total Number of Household Members: _____

Name	Date of Birth	Relationship to Applicant	Health Insurance (e.g. Medicaid, Medicare, other please specify)

Employment History List all employers during the last 3 months, beginning with the most current		
Applicant		
Employer:	From:	To:
Employer:	From:	To:
Employer:	From:	To:
Spouse/Domestic Partner		
Employer:	From:	To:
Employer:	From:	To:
Employer	From:	To:
Other Household Member		
Employer:	From:	To:
Employer:	From:	To:
Employer:	From:	To:

Middlesex Health

Assets

This form must be completed as part of the application when applying for assistance for hospital services.
Tell us about assets owned by any of the household members listed on the previous page.

Bank/Credit Union Accounts: (savings, checking, IRAs, Vacation or Christmas clubs, etc.)

Account Owner	Bank/Credit Union Name	Account #	Balance

Annuities/Trust Funds:

Account Owner	Company Name	Account #	Value

Stocks/Bonds/Mutual Funds: Itemize below or attach investment statements

Account Owner	Name of Stock or Type of Bond	# of Shares/Bonds	Value

Real Estate:

Home Owner	Location/Address

Motor Vehicles:

Automobile Owner	Make and Model	Model Year	Amount Owed

Other Assets: (Whole life insurance policies, pre-paid funeral accounts or assets recently transferred)

Description	Value

Middlesex Health

HOUSEHOLD INCOME

Sources of Income	Household Member	Amount	Frequency
Salary/Wages (gross)			☐ Wkly ☐ Bi-wkly ☐ Mthly
Salary/Wages (gross)			☐ Wkly ☐ Bi-wkly ☐ Mthly
Salary/Wages (gross)			☐ Wkly ☐ Bi-wkly ☐ Mthly
Social Security			☐ Wkly ☐ Bi-wkly ☐ Mthly
Social Security			☐ Wkly ☐ Bi-wkly ☐ Mthly
Disability			☐ Wkly ☐ Bi-wkly ☐ Mthly
Child Support			☐ Wkly ☐ Bi-wkly ☐ Mthly
Alimony			☐ Wkly ☐ Bi-wkly ☐ Mthly
Unemployment			☐ Wkly ☐ Bi-wkly ☐ Mthly
Dividends/Interest			☐ Wkly ☐ Bi-wkly ☐ Mthly
Pensions			☐ Wkly ☐ Bi-wkly ☐ Mthly
Pensions			☐ Wkly ☐ Bi-wkly ☐ Mthly
Insurance/Annuity Pymts			☐ Wkly ☐ Bi-wkly ☐ Mthly
Public Assistance			☐ Wkly ☐ Bi-wkly ☐ Mthly
Veterans Pymts			☐ Wkly ☐ Bi-wkly ☐ Mthly
Other			☐ Wkly ☐ Bi-wkly ☐ Mthly

Self Employment, Business, Rental:

Sources of Income	Household Member	Amount	Frequency
Business Income			☐ Wkly ☐ Bi-wkly ☐ Mthly
Business Expenses			☐ Wkly ☐ Bi-wkly ☐ Mthly
Net Business Income			☐ Wkly ☐ Bi-wkly ☐ Mthly

If you reported no income above, please explain how you obtain housing, food and daily living essentials and who helps you pay for your basic needs:

_____

_____

ADDITIONAL INFORMATION

Use the space below if there is other information you want the hospital to consider:

_____

_____

_____

Middlesex Health

Acknowledgement, Authorization and Certification

I hereby request that Middlesex Health make a written determination of my eligibility for Financial Assistance to pay hospital medical bills incurred at Middlesex Health.

Further, I acknowledge that:

1. I understand that the information that I submit in this application, including but not limited to my annual income and household size, is subject to verification by Middlesex Health. I understand that if this information is determined by Middlesex Hospital to be false, such a determination may result in a denial of financial assistance, and that I will remain liable for my Middlesex Hospital open accounts.
2. This application applies to services rendered by Middlesex Health. Professional fees for Pathology, Radiology, and Anesthesiology, as well as services rendered by other private physicians, clinics, and hospitals are not subject to reduction based on this application.
3. This application applies to Middlesex Health services rendered 180 days prior to my date of signature and for future services up to 180 days from the date of the application approval. I will be notified by mail of the final decision. A new application must be completed for me to be considered for financial assistance for services provided after this period.
4. My eligibility for Financial Assistance is based on household income level and my meeting donor-specified requirements placed on several of the Free-Bed Funds, when applicable. Certain of the Free Bed Fund eligibility determinations must be made by persons or organizations outside Middlesex Health. I authorize Middlesex Health to release my application information as may be necessary to obtain Free Bed Fund payment or to qualify me for any government programs I may be eligible for including but not limited to M.C.A.P.
5. For hospital services rendered at Middlesex Hospital, I may be required by Middlesex Health to apply for City/Town and/or State Assistance prior to having the cost of services reduced through this program.
6. Financial assistance approval excludes services covered under Workers' Compensation, third-party liability, cosmetic procedures or elective procedures not covered by insurance.

By signing below, I acknowledge that I understand that the information which I submit as a part of this application is subject to disclosure to federal and/or state agencies and I give my permission for Middlesex Health to share this information with others to process this application and that more information may be requested before my eligibility can be determined. All information will remain confidential under HIPAA federal regulations.

I also certify that the information submitted by me as part of this application is true and correct to the best of my knowledge and belief.

_____

Signature of Applicant or person acting on behalf of Applicant **Date**

_____

Print Name **Signature of Witness** **Date**