Middlesex Health

Instructions for Completing the Middlesex Hospital Financial Assistance Application

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

Name: _____ **Date:** _____

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 your 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 → Attached 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**
- ☐ **Please check 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 support 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 APPLICANTS:

- ☐ If you have applied for state assistance or have been required to apply for state assistance by Middlesex Hospital you must provide us with the **eligibility or denial letter received from the State of Connecticut, Department of Social Services**

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

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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 dependants 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. Qualification 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.

FONDOS PARA CAMAS GRATUITAS Y OTROS PROGRAMAS DE ASISTENCIA ECONÓMICA

Las leyes federales y estatales requieren de todos los hospitales que procuren pago por todos los cuidados proporcionados. Por lo tanto, es importante que nos deje saber si hay la posibilidad de un problema con respecto al pago de su cuenta. Si no tiene seguro de salud o se preocupa de que no pueda poder pagar por una parte de su cuidado o en su totalidad, es posible que podamos ayudar. Middlesex Health proporciona ayuda financiera a los pacientes del hospital en función de sus ingresos, activos y necesidades financieras. Además, podemos ayudarlo a obtener un seguro de salud gratuito o de bajo costo o trabajar con usted para organizar un plan de pago manejable.

En la mayoría de los casos, la asistencia económica para los fondos de camas gratuitas y otros programas de asistencia económica se basan en una escala que considera su ingreso y el número de dependientes en su familia, como se describe abajo en la tabla.

- Fondos para camas gratuitas - Los fondos para camas gratuitas provenientes de donaciones provistas a Middlesex Health. El interés ganado en estos fondos permite que el hospital provea algunos servicios sin costo o a un costo reducido. En general, usted no recibirá tales fondos si no cumple con los requisitos de ingreso establecidos en la tabla que aparece abajo. Es posible que también hayan requisitos específicos relacionados a un fondo de cama gratuita particular. Si a usted se le niega la ayuda económica de los fondos para camas gratuitas, usted puede hacer nuevamente la solicitud. Es posible que fondos adicionales para camas gratuitas se encuentren disponibles cada año.
- Otra asistencia económica – Además, Middlesex Health provee otros programas de asistencia económica. La calificación para estos programas de asistencia económica se basa, generalmente, en los requisitos de ingresos establecidos en la tabla que aparece abajo, pero sin las restricciones que puedan ser impuestas por los fondos para camas gratuitas. Estos programas de asistencia económica son mantenidos y administrados separadamente de los fondos para camas gratuitas. Si se niega la asistencia económica, usted podrá hacer otra solicitud en el futuro.

Para hacer una solicitud de, bien sea los fondos para camas gratuitas u otros programas de asistencia económica, por favor, llame al 860-358-2402 ó al 860-358-2403 para hablar con un Consejero Financiero o visítenos en el Centro Ambulatorio de Middlesex Health Outpatient Center, 534 Saybrook Rd., Middletown, CT 06457. Trataremos a sus preguntas y a toda la información que nos proporcione con respeto a su privacidad y la confidencialidad, y con cortesía.

HOUSEHOLD SIZE	**GROSS HOUSEHOLD INCOME Effective Date: February 1, 2020**	**NÚMERO DE LOS MIEMBROS DE LA CASA**	**INGRESO BRUTO DEL HOGAR Fecha de vigencia: 1 de febrero de 2020**
#	AT OR BELOW:	#	NO MÁS DE:
1	$63,800	1	$63,800
2	$86,200	2	$86,200
3	$108,600	3	$108,600
4	$131,000	4	$131,000
5	$153,400	5	$153,400
6	$175,800	6	$175,800
7	$198,200	7	$198,200
8	$220,600	8	$220,600

For more dependents, add to income for each additional member: $22,400

Para más dependientes, se suma al ingreso para cada miembro adicional: $22,400

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APPLICATION FOR FINANCIAL ASSISTANCE

Applicant Name: _____ Phone: _____

Address: _____ Cell: _____

_____ Email: _____

Spouse/Domestic Partner Name: _____

U.S. Citizen: ☐ Yes ☐ No If Yes to U.S. Citizen, State of Residence: _____

HOW DID YOU HEAR ABOUT OUR FINANCIAL ASSISTANCE PROGRAM?

☐ Web-Site ☐ Brochure ☐ Registration ☐ Customer Service ☐ Financial Counseling ☐ Billing Statement

☐ Other:_____

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: _____

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ASSETS

This form must be completed as part of the application.
Tell us about assets owned by any of the household members listed on Page 1.

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

Account Owner	Bank/Credit Union Name & Address	Account #	Balance

Annuities/Trust Funds:

Account Owner	Company Name & Address	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

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GROSS HOUSEHOLD INCOME

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

Self Employment, Business, Rental:

Sources of Income	Household Member	Amount	Frequency
Business Income			☐ Weekly Bi-weekly ☐ Monthly
Business Expenses			☐ Weekly Bi-weekly ☐ Monthly
Net Business Income			☐ Weekly Bi-weekly ☐ Monthly

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 Hospital make a written determination of my eligibility for Financial Assistance to pay hospital medical bills incurred at Middlesex Hospital.

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 Hospital. 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 Hospital. 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 Hospital 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 Hospital. I authorize Middlesex Hospital 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. I may be required by Middlesex Hospital to apply for City/Town and/or State Assistance prior to having the cost of services reduced through this program.

By signing below, I acknowledge that I understand that the information which I submit as part of this application is subject to disclosure to federal and/or state agencies and I give my permission for Middlesex Hospital 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