MASONICARE HEALTH CENTER

FINANCIAL ASSISTANCE APPLICATION FOR HOSPITAL SERVICES (Updated August 2018)

PAGE 1

DEMOGRAPHIC INFORMATION			
Patient's Last Name:	Patient's First Name:	Date of Birth:	Social Security:
Address:	City:	State:	Zip:
Home Phone:	Cell Phone:	Marital Status:	Spouse's Name:
Patient's Employer:	Patient's Employer's Address:		Employer's Phone:
Spouse's Employer:	Spouse's Employer's Address:		Employer's Phone:

INCOME INFORMATION		
Gross Monthly Income:	Patient $	Spouse $
Other Family Income:	Patient $	Spouse $
State/Public Financial Assistance:	Patient $	Spouse $
Alimony or Child Support Income:	Patient $	Spouse $
Social Security/Disability/VA Benefits:	Patient $	Spouse $
Retirement/Pension Income:	Patient $	Spouse $
Interest/Dividends/Annuities:	Patient $	Spouse $
Other Income:		
Explain Other Income:		

SELF EMPLOYMENT, BUSINESS OR RENTAL INCOME		
Business / Rental Income:	Patient $	Spouse $
Business/ Rental Expense:	Patient $	Spouse $
Net Business/ Rental Income:	Patient $	Spouse $

GRAND TOTALS	
Total Combined Household Income (total of all items above):	
TOTAL NUMBER OF HOUSEHOLD MEMBERS:	

I certify that the above information is true to the best of my knowledge and by signing this form; I agree to allow Masonicare Health Center to check employment for the purpose of determining my eligibility for financial assistance or a financial discount. I understand that I may be required to provide proof of the information listed on this application. I understand that this application is made so that the hospital can judge my eligibility for financial assistance, based on the established criteria of the hospital. If any information I have given proves to be untrue, I understand the hospital may re-evaluate my financial status and take whatever action is appropriate. I also understand all information requested must be received within (30) days from the date of this request. I understand that I may incur additional charges from other professional entities of which I may be responsible for including but not limited to independent physician services (radiologists, cardiologists, pathologists, others).

Person Completing Application (please print):_____

Applicant's Signature: _____ **Date of Request**: _____

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PAGE 2

Checklist of Required Supporting Documents

Proof of Income (provide all that are applicable):

□ If you are working, a copy of 4 (consecutive) payroll check stubs for all household members or a letter from your employer documenting your salary
□ If you are unemployed, a copy of your Unemployment Compensation Benefit Letter
□ Alimony or Child Support Determination Letter(s)
□ Letter from Social Security/Disability/Pension documenting the gross income benefit amount
□ Notarized Letter by your guarantor or person(s) supporting you
□ Documentation of interest income, dividends and/or income from any other source
□ Documentation of the total number of dependents in the household

□ If you are self-employed, a copy of your filed Federal Tax Return Forms for the previous two years- include Schedule C (Form 1040) or Schedule K1

Medicaid Determination Letter (if applicable):

If you are un-insured or if your income is under Federal Poverty Guideline level
□ Provide a copy of the eligibility determination letter you received from State of Connecticut, Department of Social Services

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ELIGIBILITY DETERMINATION
(FOR MASONICARE HEALTH CENTER OFFICE USE ONLY)

Patient Name: _____ Medical Record Number: _____

Received By: _____ Received Date: _____

Documentation Provided:

___Income ___Tax Return ___Medicaid Determination Letter

Eligibility Determination:

_____ Eligible (for next 6 months) _____Eligible Catastrophic Event Coverage

Original Balance $_____ Financial Assistance $_____ New Balance $_____

_____ Applicant is denied Reason for denial: ___Over income ___ Did not pursue available resources
___ Failed to comply with application requirements
___ Other reason: _____

Financial Services Department Authorization:

Authorized Signature: _____Determination Date:_____

Authorized Name (please print): _____Title: _____