Aplikasyon pou Èd Finansye
*(Aplikasyon an Dwe Ranpli **Nèt**)*

Dat Demann lan: ____/____/_____

Enfòmasyon pasyan an:
Siyati: _____ Prenon _____ Inisyal Dezyèm Prenon ___

Dat Nesans: _____/_____/_____ Nimewo Sekirite Sosyal: _____-_____-_____

Adrès: _____ Nimewo Apatman an _____

Vil: _____ Eta: _____ Kòd postal: _____

Nimewo Telefòn Kay la (____) _____ Lòt Nimewo Telefòn (____) _____

Depandan ki nan kay la:

	Non	Dat Nesans	Relasyon ak Pasyan an
1.			
2.			
3.			
4.			
5.			

Enfòmasyon sou Revni:

Revni	Pasyan	Mari/Madanm
Patwon		
Salè Brit		
Sipò Timoun/Pansyon Alimantè yo te Resevwa		
Pansyon		
Avantaj pou Chomaj		
Avantaj Sekirite Sosyal		
Revni pou Lokasyon		
Lòt Revni		
Koupon Pou Achte Manje		
Revni Total		

Tanpri bay kopi dokiman ki disponib yo sou lis Dokiman ak Fòm Verifikasyon ki tache a. Pasyan yo dwe bay enfòmasyon sa a nan lespas 15 jou apre yo fin resevwa aplikasyon an. Tout enfòmasyon yo bay, yo diskite oswa yo anrejistre ki gen relasyon ak aplikasyon sa a konfidansyèl. Si ou gen kesyon oswa si ou bezwen plis èd kontakte yon Konseye Èd Finansye nan (203) 276-7515 oswa (203)276-4831 nan Depatman Biznis Pasyan an.

Lòt enfòmasyon aplikan an vle yo pran an konsiderasyon:

_____

_____

_____

Mwen mande Lopital Stamford èd finansye, ki gen ladan aksè ak fon kabann lopital ki ka disponib epi mwen ka kalifye pou li. Mwen konprann Stamford Hospital te verifye enfòmasyon mwen te soumèt yo. Mwen sètifye enfòmasyon ki anwo la a se verite epi kòrèk. Mwen konprann yo ka mande mwen pou m aplike pou èd piblik, si m kalifye.

Siyati Aplikan an: _____ Dat:_____

Tanpri sonje si w pa rive ranpli aplikasyon sa a ak bay enfòmasyon yo mande nan delè yo bay la pral retade pwosesis demann ou an epi sa ka lakòz yon detèminasyon ou pa kalifye pou èd finansye.

SÈLMAN PÈSONÈL LOPITAL LA KI KA EKRI LA A

MR#: _____

Gwosè Fanmi an#_____

Nivo Èd Finansye Yo Apwouve: _____@_____%

FAP Apwouve: Moun ki Voye li a: _____ Pou: _____

Pandan Gwosès Yo Apwouve: Moun ki Voye li a: _____ Pou: _____

Dat Refi a: _____

Rezon Refi a: _____

Daprè FC: _____ Dat: _____

Fòm Dokimantasyon ak Verifikasyon

Tanpri bay Konseye Èd Finansye w la oswa Depatman Sèvis Biznis Pasyan an dokiman ki aplikab ki nan lis anba a pou aplikan/mari oswa madanm oswa lòt moun enpòtan ak timoun (si aplikan an se yon minè bay enfòmasyon paran an).

TANPRI FÈ NOU JWENN KOPI DOKIMAN SA YO

Asirans:

Sante	☐ WI oswa ☐ NON	Responsablite	☐ WI oswa ☐ NON
Asirans pou aksidan nan travay	☐ WI oswa ☐ NON	MVA	☐ WI oswa ☐ NON
Eske ou te aplike pou pwoteksyon asirans ak Access Health CT			☐ WI oswa ☐ NON

TOUT ENFÒMASYON YO MANDE YO SE POU PASYAN, MARI OSWA MADANM, LÒT MOUN ENPÒTAN, PATNÈ AK TIMOUN NAN KAY LA.

Avantaj Federal ak Eta yo:

☐ Lèt Refi Depatman Sèvis Sosyal
☐ Koupon pou Achte Manje /Lèt Èd Lajan Kach
☐ Pwoteksyon Medikal Depatman Sèvis Sosyal (Medicaid)
☐ Lèt Avantaj Sekirite Sosyal

Idantifikasyon:

☐ Pyès Idantite ki gen Foto / Lisans chofè / Paspò / Kat Rezidan Pèmanan
☐ Prèv Adrès Aktyèl la (fakti sèvis piblik, kab, telefòn)
☐ Batistè Timoun

Revni: salè, salè, tep, ak dividann

☐ Dènye Deklarasyon Taks Ou Ranpli ak W-2 oswa 1099
☐ Dènye Souch Chèk (4 si yo peye chak semèn / 2 si yo peye chak de (2) semèn epi 2 si yo peye chak mwa)
☐ Lèt notarye ki soti nan men patwon an oswa nan men ou
☐ Istwa peman chomaj (si gen rekouvreman chomaj)
☐ Si ou p ap travay tanpri bay yon lèt notarye ki endike kijan ou sipòte tèt ou.
☐ Pansyon Alimantè ak Sipò Timoun (Dokiman Tribinal oswa yon lèt notarye ki endike kantite lajan ou resevwa)

Enfòmasyon sou Rezidans lan

☐ Resi Lwe / Kontra Lwaye oswa Deklarasyon Ipotèk
☐ Lèt notarye ki soti nan men mèt kay la oswa nan men ou (kantite lajan ou peye pou lwaye chak mwa)
☐ Lèt abri

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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. 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.

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 or significant other 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, SIGNIFICANT OTHER, PARTNER 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 Filed Tax Return and W-2 or 1099
□ Most Recent Pay Stubs (4 if paid weekly / 2 if paid bi-weekly and 2 if paid monthly)
□ Notarized letter from employer or self
□ Unemployment payment History (if collecting unemployment)
□ If unemployed please provide a notarized letter indicating how you support yourself.
□ Alimony and Child Support (Court document or a Notarized letter indicating amount received)

Residence Information:

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