Patient Financial Counseling
UConn Health
263 Farmington Avenue
Farmington, CT 06030-8231
860.679.4120

# FINANCIAL ASSISTANCE APPLICATION

Date of Application: _____ Patient's Name: _____

Address: _____ Phone: _____
Street City Zip

Number of People in Household: _____ Medical Record Number: _____

**FAMILY MEMBERS**
(List Patient First)

| | Name(s) | Relationship | Sex | DOB | Age | SSN | Address | Phone |
|---|---|---|---|---|---|---|---|---|
| 1. | | | | | | | | |
| 2. | | | | | | | | |
| 3. | | | | | | | | |
| 4. | | | | | | | | |
| 5. | | | | | | | | |

**For additional members, please attach extra sheets to this application.**

Financial assistance requested by: _____ Relationship to patient: _____

**The following documents are required in order for your application to be processed. Please provide as many of these as you can, and place a check mark next to the items you attached to this application. Thank you.**

☐ Previous year's income tax return 1040/1040A (must include Schedule C if self-employed)

☐ Last paystub showing year-to-date (YTD)

☐ Other source of income

☐ If receiving Social Security, please supply Social Security award letter

☒ Must provide proof of Connecticut residency (required)
(Example: Connecticut driver's license, cable bill, telephone bill, light and power bill, etc.)

**INCOME FOR LAST 12 MONTHS**

Over Asset _____ Over Income _____ 5 Year Rule N/Eligible _____

Initials _____

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## EMPLOYMENT INFORMATION

Please list your employment information. If employed for the less than two years, please list previous employer.

| | Name | Employer | Address | Phone | Position | Employment Start Date | Employment End Date |
|---|---|---|---|---|---|---|---|
| 1. | | | | | | | |
| 2. | | | | | | | |
| 3. | | | | | | | |

## OTHER SOURCES OF INCOME

Please list all other sources of income below.

1. _____

2. _____

Are you presently able to work? _____ Yes _____ No (If "No", please explain.)

Is any family member able to work? _____ Yes _____ No (If "No", please explain.)

What is your total household income for the last twelve (12) months? _____

**I certify that the information presented on this application is correct and true.**

_____ _____
Signature Date

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**FOR UCONN HEALTH USE ONLY**

What is total outstanding UConn Health balance?

UConn Medical Group $_____

UConn John Dempsey Hospital $_____ Pending Services: Yes ____ No ____

TOTAL $_____

Has the patient been approved for financial assistance within the last 6 months? ____ Yes ____ No

This document was received on _____ by _____

The request for financial assistance is: ☐ Approved for a discount of % _____
☐ Denied, reason for denial _____

Copy of determination is attached.

| _____ | _____ | _____ |
|---|---|---|
| Signature | Date | Application Number |

**Note: Application must be returned in 90 days or it will be denied.**