HOSPITAL *FOR SPECIAL* CARE
FINANCIAL ASSISTANCE APPLICATION

Name ____ Telephone _______________

Address____

HOUSEHOLD MEMBERS (LIST YOURSELF FIRST)

Name(s)	Relation	Sex	Date of Birth	Birthplace	Social Security #

If you or any member of the household is pregnant, list name ________________ and due date ____________

Are you a U.S. Citizen? _____ Yes ___ No If no, Give Alien Status _________ and number __________

U.S. Entry Date __________ Place of Entry _________________ and Country of Origin ______________

EMPLOYMENT INFORMATION

Please list the present or last employer for you and anyone else earning income in your household.

Name	**Employer**	**Position**	**Hire Date**	**End Date**	**Reason for Leaving**

CURRENT INCOME

Wage Earner Name	**Employer**	**Hours/Wk**	**(Circle One) Amt. (Per Month/Week) (Gross)**

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OTHER INCOME	YES	NO	Date Applied	Amt. Per Mo/Wk (Gross)
SSI	___	___	____________	$_______________________
Social Security	___	___	____________	$_______________________
Pension	___	___	____________	$_______________________
Annuities	___	___	____________	$_______________________
Worker's Compensation	___	___	____________	$_______________________
Unemployment Compensation	___	___	____________	$_______________________
Veteran's Benefits	___	___	____________	$_______________________
Military Allotment	___	___	____________	$_______________________
Sick/Disability Benefits	___	___	____________	$_______________________
Boarder/Roomer Income	___	___	____________	$_______________________
Rental Property Income	___	___	____________	$_______________________
Child Support/Alimony	___	___	____________	$_______________________
Other (type & source)	___	___	____________	$_______________________

If you have no income, please explain how you have been meeting your medical/basic living needs.

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ASSETS

Do you or anyone in your household have any of the following?

Cash on Hand ________ Yes _______ No   If yes, amount $_____________

Bank or Credit Union Accounts _______ Yes _______ No If yes, complete below:

Name of Bank/Credit Union	Address	Account #	Type	Balance
__________________________	_____________	_____________	_____________	$___________
__________________________	_____________	_____________	_____________	$___________
__________________________	_____________	_____________	_____________	$___________
__________________________	_____________	_____________	_____________	$___________

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Annuities, Trusts and/or Stocks & Bonds **__ Yes ___ No If Yes, complete below:**

Name of Company/Institution	Account Number	Number of Shares	Current Value
______________________	________________	________________	________________
______________________	________________	________________	________________

Motor Vehicle(s) cars motorcycles, trailers, campers, boats, etc. **______ Yes _____ No**

Type	Make	Model	Year	Registration #	NADA Value	Loan Balance	Equity
______	_____	______	____	__________	__________	__________	______
______	_____	______	____	__________	__________	__________	______
______	_____	______	____	__________	__________	__________	______
______	_____	______	____	__________	__________	__________	______

Life Insurance: **_______ Yes ______ No If Yes, complete below:**

Insured	Company Name	Effective Date	Face Value	Cash Value
______________	__________________	___________	________	_________
______________	__________________	___________	________	_________

Real Property: **_______ Yes ________ No If Yes, complete below:**

(House/Land/Rental Property/Etc.)

Location and Type of Property	Mortgage Holder	Current Loan Balance
____________________________	___________________	____________________
_____________________________	___________________	____________________

Other Assets: **_______ Yes ________ No If Yes, please explain: _________________________**

MILITARY HISTORY

Have you or anyone else in your Household served in the military? _____ Yes ____ No

If Yes, Name: ______________________Dates of Service:________________________________

Branch of Service: __________________________________ Disabled Veteran: ____ Yes ____No

Applied to: Sailor, Soldier, Marine Fund: ____ Yes____ No If Yes, date of application: __________

Applied to: Veterans' Administration:_____ Yes _____ No If Yes, date of application: ___________

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MEDICAL INSURANCE/BENEFITS

Person Covered	Source & Type (ie., Insurance Carrier/HMO)	ID/Case Number	Effective Date
________________	________________	___________	________________
________________	________________	___________	________________
________________	________________	___________	________________

EXPENSES

RENT	**Monthly/Weekly**	***OWNED PROPERTY***	**Monthly/Weekly**
Apartment/House	**$________________**	**House**	$______________
Room and Board	**$________________**	**Condominium**	**$______________**
Room Only	**$________________**	**Mobile Home**	**$______________**
Other (explain)	**$________________**	**Other (explain)**	**$______________**
Rent includes (please check)		**Mortgage Expense**	**$________________**
Hot Water ___ Heat __ Electric __ Gas ____		**Yearly Taxes**	**$________________**

UTILITY EXPENSE		***CREDIT CARD DEBT***	
Heat/Electric/Gas	$____________________	Creditor	Monthly Payment
Telephone	$____________________	____________	$____________
Cable TV	$____________________	____________	$____________
Water	$____________________	____________	$____________

OTHER MISCELLANEOUS HOUSEHOLD EXPENSES

(CIRCLE ONE)

Child Support/Alimony	$__________________	weekly/monthly/yearly
Car/Vehicle Loan	$__________________	weekly/monthly/yearly
Car/Vehicle Insurance	$__________________	weekly/monthly/yearly
Health Insurance	$__________________	weekly/monthly/yearly
Life Insurance	$__________________	weekly/monthly/yearly
Tuition/Student Loan	$__________________	weekly/monthly/yearly
Hospital/Physician Expense	$__________________	weekly/monthly/yearly
Child Care	$__________________	weekly/monthly/yearly
Personal Loan	$__________________	weekly/monthly/yearly
Other (list)	$__________________	weekly/monthly/yearly
	$__________________	weekly/monthly/yearly

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APPLICANT

RIGHTS AND RESPONSIBILITIES

1. I hereby request Financial Assistance from Hospital for Special Care.

2. I certify that all statements made by me on this application are true and correct, under penalty for false statement, as provided by the Hospital for Special Care's Financial Assistance Policy.

3. I understand that I have a right to appeal if I am dissatisfied with the Hospital's decision on my application.

4. I agree that the information provided by me on this application must be verified; and I agree to provide documentation as requested.

5. I authorize Hospital for Special Care to conduct an investigation to establish my eligibility, and give the hospital permission to obtain personal and/or financial information necessary from, but not limited to, the following sources: banks, credit unions and other financial institutions, employers, medical providers, landlord, credit agencies, and other State and federal agencies such as the Department of Social Services, the Department of Labor, the Social Security Administration, Department of Veterans Affairs, and the Immigration and Naturalization Service.

6. I agree to complete the application process for any Third Party Benefits for which I may be eligible, including Health Insurance, Veterans Benefits, etc. Further, I agree to apply for and complete the application process for State Medical Aid and/or Town Medical Aid.

______________________________ ______________
Signature of applicant Date

______________________________ ______________
Signature of Spouse/Interpreter/Witness Date

______________________________ ______________
Signature of Patient Account Representative Date

MAIL TO: Hospital for Special Care, 2150 Corbin Avenue, New Britain, CT 06053
Attn: Patient Account Representative

Hospital *for Special* Care

Appeal of Eligibility Determination for Charity Care

____

Patient or Guarantor Name

____

Address

____

City, State, Zip Code

The Charity Care decision was received on ______________________________.

Check one:

____________ I am appealing the decision of **denial** of Charity Care.

____________ I am appealing the decision of the **percentage** that was approved.

Based on the following information, please reconsider my application for Charity Care based on the following:

____

____

____

____

____

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____

Please attach any documents that support the above information.

___________________________________ ________________________________

Signature Date