Eastern Connecticut Health Network

71 Haynes St.
Manchester Ct. 06040

Phone: 860-646-1222 ext. 2768

FINANCIAL ASSISTANCE APPLICATION GUIDELINES

Please complete the financial assistance application and include all necessary information.

Your application will be denied if missing information or incomplete.

Please include:

- Proof of income for all wage earners in Household
  - Your most recent tax return and W2
  - Your last four (4) pay stubs
  - Social Security Statements
  - Unemployment Weekly Payment Benefit Statement(s) From start to present
  - Pension Statement(s)
  - Completion of all sections and sign application

Due to the high volume of applications, please, allow four to six weeks from the date we receive your application for review and determination. Once the application has been reviewed, you will be notified by mail of your application status and/or if additional information is needed.

Please return completed applications including your Medicaid denial and **all** required information to:

ECHN
71 Haynes St.
Manchester, CT
06040

ATTN: Patti Kelly
Patient Financial Advocate

Completed applications with document copies can be dropped off to the Patient Financial Advocate office located on the ground level entrance of Manchester Memorial hospital for any services for ECHN facilities.

Call to schedule a free, private and confidential appointment 860-646-1222 x2768

Eastern Connecticut Health Network

PATIENT NAME:	
PATIENT ACCOUNT #:	DATE OF BIRTH:
EMAIL ADDRESS	

I. PATIENT/RESPONSIBLE PARTY					
LAST NAME	FIRST NAME		MI	MARITAL STATUS	SOCIAL SECURITY #
STREET ADDRESS					
CITY	STATE	ZIP	HOW LONG AT THIS ADDRESS?		PHONE
EMPLOYER'S NAME AND ADDRESS				BUSINESS PHONE	LENGTH OF EMPLOYMENT
POSITION/TITLE				**MONTHLY GROSS INCOME** $	RENT OR MORTGAGE AMT $

II. SPOUSE'S INCOME/OTHER HOUSEHOLD MEMBER					
LAST NAME	FIRST NAME		MI	MARITAL STATUS	SOCIAL SECURITY #
STREET ADDRESS					
CITY	STATE	ZIP	HOW LONG AT THIS ADDRESS?		PHONE
EMPLOYER'S NAME AND ADDRESS				BUSINESS PHONE	LENGTH OF EMPLOYMENT
POSITION/TITLE				**MONTHLY GROSSINCOME** $	

PROOF OF INCOME FOR ALL WAGE EARNERS IN HOUSEHOLD
****proof of **current** income documents must be attached **including** the most recent Federal Income Tax Form (1040)
Current Federal Income Tax Form (1040) REQUIRED _____
Previous Year W2 Form(s)_____
Last 4 pay stubs: _____ **(if you are currently employed pay stubs must be included)**
Social Security Statement(s)_____
Unemployment Weekly Benefit Statement(s)_____
Pension Statement(s)_____
Please note other income documents may be requested in order to determine financial assistance

When Third Party coverage is available (Medicare, Medicaid, etc.) all applicable benefits must be applied first.
To apply for Medicaid, please visit the How to Apply page at Husky Healthcare -CT.gov. It must be determined that you are ineligible for Medicaid to be considered for Financial Assistance.
ECHN is committed to providing financial assistance to persons who have health care needs and are uninsured, underinsured, ineligible for a government program (Medicaid/Husky) or otherwise unable to pay, for emergency or medically necessary care based on their individual financial situation.

III. HOUSEHOLD INFORMATION (ALL PERSONS IN HOUSEHOLD)		
NAME	DOB	RELATIONSHIP

LIST ADDITIONAL MEMEMBERS OF HOUSEHOLD ON BACK OF APPLICATION

IV. MISCELLANEOUS GROSS INCOME PER MONTH			
DIVIDENDS, INTEREST	$	PENSIONS	$
CHILD SUPPORT/ALIMONY	$	OTHER	$
SOCIAL SECURITY	$		$
UNEMPLOYMENT/WORKER'S COMPENSATION	$	RETURN TO WORK DATE	
PROPERTY	$	INVESTMENT/RENTAL INCOME	
TOTAL MONTHLY MISCELLANEOUS GROSS INCOME:	$		

V. MONTHLY GROSS INCOME		
PATIENT/ RESPONSIBLE PARTY'S MONTHLY INCOME		$
SPOUSE's MONTHLY INCOME (If Applicable)	+	$
TOTAL MONTHLY MISCELLANEOUS INCOME	+	$
TOTAL MONTHLY GROSS INCOME	**=**	**$**

INCOMPLETE OR FRAUDULENT
****APPLICATIONS WILL BE DENIED***

IN COMPLETING THIS FINANCIAL STATEMENT, I HEREBY AFFIRM THAT THE ABOVE STATEMENTS ARE CORRECT AND COMPLETE, AND I GIVE MY CONSENT TO FURTHER VERIFICATION BY ECHN OR ITS AGENTS.

I understand that this information may be shared with my providers (ECMP) as they are part of ECHN.
I understand that any payments previously made on accounts is not refundable nor applicable to any discount approved as part of this Financial Assistance Application.

SIGNATURE/ DATE: _____/_____

: _____

APPROVED _____%

DENIED _____

Mail application to: 71 Haynes St.
Manchester, Ct 06040
Attention: Patti Kelly/Patient Financial Advocate
Patient Access Department

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