Griffin Health Services Corporation
Griffin Hospital

Uninsured Eligibility _____
Free Care Eligibility _____

Application Date: _____

Financial Assistance Application **Patient Acct. #**

1. Patient's Information:

Last Name	First Name	Middle Initial	Social Security No.	Date of Birth

Street Address	City	State	Zip Code

_____ Check one: ☐Single ☐Married
Home Phone Number Work Phone Number ☐Separated**** ☐Divorced ☐Widowed
******Include copy of legal separation agreement**

2. Person Responsible for paying the bill:

Last Name	First Name	Middle Initial	Relationship to Patient	Social Security No.

Address if different from patient

_____
Name of Insurance Company Effective Date

3. **Please indicate ALL dependents living in the household, including applicant. *Use additional sheet of paper if needed.***

	NAME	RELATIONSHIP TO PATIENT	DATE OF BIRTH	SOC. SECURITY #
1.				
2.				
3.				
4.				
5.				
6.				

4. Is this application for future or past services? ☐Future ☐Past Date(s) of Services: _____

5. Has anyone in your household applied for CT HUSKY or Medicaid? ☐Yes ☐No Who:_____
When? _____ What is the status? ☐Pending ☐Denied Reason: _____

6. Has anyone in your household served in the military? ☐Yes ☐No Who: _____

7. Have you recently filed a workers' compensation claim? ☐Yes ☐No Date: _____

8. Is anyone in your household eligible for Social Security benefits: ☐Yes ☐No Who: _____

9. Is anyone in your household covered by health insurance? ☐Yes ☐No Who: _____

Name of insurance company: _____

10. HOUSEHOLD INFORMATION	**PERSON #1**	**PERSON #2**	**Financial Advisor Only**
Section 10 requires proof of income. Please supply copies. Please indicate N/A if not applicable. ******Enclose copy of most recent COMPLETE tax return.** ******Enclose copy of statement showing current value for IRA, 403B, 401K, if applicable**			
**Name of each household member:	_____	_____	_____
Monthly Income From:			
W-2/Employment ☐ paid weekly ☐ paid bi/weekly *****Include copies last 3 paystubs**	$	$	$
Self-Employment	$	$	$
Investment Accounts:	$	$	$
Real Estate rentals:	$	$	$
Unemployment: since (___/___/___)	$	$	$
Retirement: (Soc. Security, Pension, Annuity)	$	$	$
Alimony/Child Support	$	$	$
Public Assistance, Food Stamps	$	$	$
Other Income	$	$	$
Savings and Investments:			
Checking Account Balances: 3 consecutive complete statements	$	$	$
Savings & CD Account Balances	$	$	$
IRAs, 403B, 401K Specify: _____	$	$	$

Other savings and investments: Specify: _____	$	$	$
Other:			

11. OTHER COMMENTS ☐ Check here if you have attached additional information you would like considered with your application.

12. ASSIGNMENT OF RIGHTS Read Carefully

By signing below, I authorize the request for my credit report and/or tax return. I understand that a tax return may be needed to process this application and that more information may be requested before my eligibility can be determined.

By signing below, I certify that all information I have submitted is true. I understand that any incorrect, incomplete or false information that I provide or someone else provides for me could cancel my application for financial assistance.

All adult household members who sign below authorize the release of any medical, financial or employment information which relates directly to their health care or to their financial assistance eligibility. This information may be released to any health care providers from whom household members have sought health care services or financial assistance. All information provided will remain confidential under the provisions of HIPAA federal regulations. Elective procedures may not be considered for assistance.

I agree that I will repay the full financial assistance award if I receive payment of any kind for the medical services covered by this application, for example insurance payments, government program payments, award from a lawsuit or any other payment.

If I receive Financial Assistance, I agree to tell the organization where I first applied of any changes which could impact eligibility, including changes to family size, income and health insurance coverage. I understand that if my/our medical situation changes so that I/we might be eligible for a public assistance program, I will need to apply to that program and provide proof of application.

_____ _____

Signature Date Signature Date

Applicant Signature Financial Advisor Signature