

**PATIENT FINANCIAL ASSISTANCE PROGRAM APPLICATION**

Applicant's Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: ( ) \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Family Members** (List all family members living in household and their date(s) of birth):

Name	Date of Birth	Name	Date of Birth
1. _____	/_____/_____	4. _____	/_____/_____
2. _____	/_____/_____	5. _____	/_____/_____
3. _____	/_____/_____	6. _____	/_____/_____

**\*\*\* APPLICANTS MUST SUBMIT ALL REQUIRED DOCUMENTS IN THE SAME MAILING.**

**THE FOLLOWING DOCUMENTATION IS REQUIRED TO DETERMINE ELGIBILITY:**

<p><b>1. Proof of income:</b> (Submit all documentation that applies to your household)</p> <p><input type="checkbox"/> Pay stubs for <b>most recent 4 weeks</b> for each working member of household.</p> <p><input type="checkbox"/> Unemployment or Workers Compensation Statement.</p> <p><input type="checkbox"/> Social Security benefit letter or bank statement, if you use Direct Deposit</p> <p><input type="checkbox"/> Pension statement.</p>	<p><b>Other resources (continued):</b></p> <p>B. Do you own property that you do not live in?</p> <p><input type="checkbox"/> YES (please attach copy of current assessed value)</p> <p><input type="checkbox"/> NO</p> <p>C. Do you have any other sources of income:</p> <p><input type="checkbox"/> YES (please attach letter with description)</p> <p><input type="checkbox"/> NO</p>
<p><b>2. Other resources:</b></p> <p>A. Do you have checking, savings, stocks or bonds?</p> <p><input type="checkbox"/> YES (please provide 3 consecutive statements)</p> <p><input type="checkbox"/> NO</p>	<p>D. Do you have a pending lawsuit?</p> <p><input type="checkbox"/> YES (please attach assignment letter)</p> <p><input type="checkbox"/> NO</p>

I affirm by my signature below that the information contained on this application is true to the best of my knowledge. I agree to provide additional information as requested in order to inform St. Vincent's promptly of any changes in my needs, income, living arrangements or address. Based on the determination of this application for reduced charges, I hereby agree to pay such fees at the time the service is rendered. You may be required to apply for Medicaid assistance before your request can be approved.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Relationship (if other than patient)

\_\_\_\_\_  
Date

**OFFICE USE ONLY**  
Discount % Approved \_\_\_\_\_  
Date Approved \_\_\_\_\_  
Approval Signature \_\_\_\_\_

**MAIL APPLICATION TO:**  
St. Vincent's Medical Center Patient Access  
2800 Main Street, Bridgeport, CT 06606  
Phone (203) 576-5911 or (203) 576-5829  
financial.assistance@stvincents.org