TRUST. VINCENT'S

Patient Financial Assistance Program Application

Applicant's Name: _____MR#_____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: ( ) _____ Date of Birth: _____

Family Members (List all family members living in household and their date(s) of birth. Children age 19 and over must apply separately):

Name	Relationship	Date of Birth
1.		
2.		
3.		
4.		
5.		

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

THE FOLLOWING DOCUMENTATION IS REQUIRED TO DETERMINE ELIGIBILITY

1. Proof of identity. Please provide copies of photo ID, passports, resident cards, birth certificates, social security cards of all family members on the application, proof of address, rent or mortgage.

2. Proof of income: (submit all documentation that applies to your household)
   - Pay stubs for most recent 4 weeks, for each working member of household
   - Unemployed or Workers Compensation statement
   - Social Security benefit letter or bank statement, if you use Direct Deposit
   - Pension statement
   - Child support or Alimony
   - Rent income
   - Most recent tax return filed

3. Other resources:

   A. Do you have checking or savings accounts?
   - ☐ Yes
   - ☐ No

   B. Do you have any other sources of income?
   - ☐ Yes
   - ☐ No

   C. Have you recently been denied medical coverage by the Department of Social Services (DSS)?
   - ☐ Yes
   - ☐ No

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 _____

Elizabeth Pereira - Charity Counselor Patient Access
(203) 576-6257 / F (203) 382-2430
2800 Main Street, Bridgeport, CT, 06606 / epereira@stvincents.org

St. Vincent's Medical Center