Hebrew HealthCare

Hebrew Health Care Financial Aid application instructions and Required Documents

In order to consider you for financial assistance, the entire application must be completed and signed by you (or the responsible party). Please note that all information submitted on the form will be verified through legitimate agencies.

Please provide the following documents that apply to your household. Please submit only copies – no original documents, if applicable.

- **Copy** of Federal Income Tax Return for Self and Spouse, of the latest one you have filed, (if within the last 5 years.)
  (Please send only the first two pages of your tax return – 1040 forms).
- Two **copies** of your most recent pay stubs for self and spouse. (if within the last 12 months)

========== **IMPORTANT!** ==========

Failure to submit the requested documents or providing incorrect information on the application will result in the **DENIAL** of your application leaving you responsible for the entire balance.

If you have any questions or need additional time to submit your application please call (860)523-3953.

If you prefer to send the verifications via fax; our fax number is (860) 523-3836.

Return the completed, signed application with the supporting documents to:

Hebrew Health Care, Inc.
Financial Aid Office
1 Abrahms Boulevard
West Hartford, CT 06117

Hebrew HealthCare
One Abrahms Boulevard
West Hartford, CT 06117-1525
Tel: 860.523.3800
Admissions: 860.218.2323
Fax: 860.523.3949
www.hebrewhealthcare.org

Hebrew HealthCare

Patient Financial Assistance Application

Today's Date: _____ Your Telephone Number: ( )_____

Applicant (or parent): Last Name: _____ First Name: _____ MI:____

Social Security Number: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Marital Status: ____Married ____ Single ____Widowed _____ Divorced ____ Separated

Background Information	Yes	No
Do you have children under 18 who live with you?		
Are you employed?		
Do you have medical insurance?		
Are you on disability?		
Are you a veteran?		
Are you currently receiving Medicaid benefits?		

Financial Information:

What are the amounts and sources of family income? *(Include wages/salary/income from any source for patient and spouse or responsible party)*

Source of income	Amount/Value
Wages/Salary	
Any other income?	
Do you own any automobiles? If yes, please state gross estimated value	
Total Balance in your checking, saving, CD, or securities	
Do you have any individual retirement accounts (IRA, 401K etc.)	
Do you own or rent your home? If you own, please state current value:	
Do you have other assets in US or other country? If yes, please state gross estimated value. (List all assets and value on a separate page and attach)	

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PAFS OFFICIAL USE ONLY – DO NOT WRITE BELOW THIS LINE

APPLICATION RECEIVED ON: _____

APPLICATION APPROVED _____ DENIED _____
Reason for denial: _____

Hospital Representative/Management Signature and Date: _____

(please turn over)

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I certify under the penalty of perjury that the information I have provided is correct, true and complete to the best of my judgment. I also give permission for verification of all facts relating to my eligibility.

ACKNOWLEDGEMENT

Patient or guarantor signature _____

Witnessed by _____Date _____

Address of above _____

City _____State _____

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