ECHN℠
Eastern Connecticut Health Network

PATIENT NAME:	
PATIENT #:	
MEDICAL RECORD #:	

I. PATIENT/RESPONSIBLE PARTY

LAST NAME	FIRST NAME	MI	MARITAL STATUS	SOCIAL SECURITY #
STREET ADDRESS				
CITY / STATE / ZIP			HOW LONG AT THIS ADDRESS?	HOME PHONE
EMPLOYER'S NAME AND ADDRESS			BUSINESS PHONE	LENGTH OF EMPLOYMENT
POSITION/TITLE			**MONTHLY INCOME** $	PAY PERIOD

II. SPOUSE'S INCOME

LAST NAME	FIRST NAME	MI	MARITAL STATUS	SOCIAL SECURITY #
STREET ADDRESS				
CITY / STATE / ZIP			HOW LONG AT THIS ADDRESS?	HOME PHONE
EMPLOYER'S NAME AND ADDRESS			BUSINESS PHONE	LENGTH OF EMPLOYMENT
POSITION/TITLE			**MONTHLY INCOME** $	PAY PERIOD

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 Benefit Statement(s)_____
Pension Statement(s)_____

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

IV. MISCELLANEOUS INCOME PER MONTH			
DIVIDENDS, INTEREST	$	PENSION(S)	$
CHILD SUPPORT/ALIMONY	$		$
SOCIAL SECURITY	$		$
UNEMPLOYMENT/WORKER'S COMPENSATION	$	Other	$
INVESTMENT/RENTAL INCOME	$		
TOTAL MONTHLY MISCELLANEOUS INCOME:	$ 0		

VI. MONTHLY INCOME		
PATIENT/ RESPONSIBLE PARTY's MONTHLY INCOME		$ 0
SPOUSE's MONTHLY INCOME (if applicable)	+	$ 0
TOTAL MONTHLY MISCELLANEOUS INCOME	+	$ 0
	-	$ 0
TOTAL MONTHLY NET INCOME	**=**	**$ 0**

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 (ECHN Medical Group) 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: ECHN
Attention: Patient Financial Advocate/Patient Access Department
71 Haynes Street
Manchester, CT 06040

Phone: 860-646-1222 ext. 2768 Fax: 860-647-4785

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FINANCIAL ASSISTANCE APPLICATION GUIDELINES

Please complete the financial assistance application and include all the information. Failing to submit all information requested will delay processing and the application may be denied.

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 required information to:

ECHN
Attention: Patient Financial Advocate/Patient Access Department
71 Haynes Street
Manchester, CT 06040

Thank you,

Your Patient Financial Advocate