



FINANCIAL ASSISTANCE PROGRAM

Date Received: _____

Application for Financial Assistance

Last Name:		First:	Telephone No:	
Street:		City:	State:	Zip:
Dependents: List family members/or others living with you and supported by you:				
Name		Date of Birth	Social Security Number	
Earned Income – (Attach the supporting documentation)				
Employee Name	Employer	Date Employed from	Date Employed to	Amount Earned
Unearned Income per month – (Attach the supporting documentation)				
Social Security: \$		Disability: \$	Veteran's Benefit: \$	
Unemployment Compensation: \$		Alimony/Child Support: \$	Pension: \$	
Worker's Compensation: \$		Public Assistance: \$	Any other income: \$	
List bills for which application is being made.				
Name of Patient	Account Number	Date of Service	Dollar Amount	

In compliance with the United States Code, Title 42, Section 291E, and the regulations pursuant thereto I do certify that the information I have submitted is true and factual and that this information may be verified.

I agree to complete the application process for any Third Party Benefits for which I may be eligible, including Health Insurance, Veterans Benefits, etc. Further, I agree to apply for and complete the application process for State Medical Aid.

Signature of Applicant _____

Date _____

MAIL TO: Windham Hospital
 112 Mansfield Avenue
 Willimantic, CT 06226
 ATTN: Financial Counselor