DKH DAY KIMBALL HEALTHCARE

FINANCIAL ASSISTANCE PROGRAM

Instructions for completing the Day Kimball Hospital Charity Care Application

Please be sure to complete the entire application and attach the requested information. Incomplete applications will not be processed and will be returned.

Income: Whether employed, unemployed or retired, you must submit proof, as listed below, of all sources of earned and non-earned income.

- ❑ Most recent complete Federal Income Tax Return. ***If you do not have a copy you may be required to complete IRS Form 4506-T requesting a transcript of your most recent tax return be sent to Day Kimball Hospital. (A financial counselor can help you with this.)***
- ❑ If a Federal Income Tax Return is not filed. ***If you claim you did not file a Federal Tax return you may be required to complete Form 4506-T requesting a confirmation from the IRS that you did not submit a tax return and have it sent to Day Kimball Hospital. A financial counselor can help you with this.***
- ❑ Gross total family income for the last 3 months. (Pay stubs or a written letter from employer verifying income for the last 3 months.)
- ❑ If you have no earned income in the previous 3 months, submit a letter from the person providing you with food, shelter, etc.
- ❑ Copy of your benefits payment history statement from Unemployment Compensation Office stating the amount you have received and for how long you are eligible to receive this benefit.
- ❑ Copies of checks or vouchers for all non-earned income, such as:
    - ❑ Social Security Benefits amount statement (your current year benefit statement from social security)
    - ❑ Veteran's Administration benefits
    - ❑ pension plan benefits
    - ❑ disability
    - ❑ child support
    - ❑ alimony
    - ❑ other_____
- ❑ Please return documents by _____
- ❑ Return documents to Day Kimball Hospital Financial Counselors, Monday – Friday, 8:00 am – 4:00 pm; or by mail: Day Kimball Hospital, Att: Financial Counselors, 320 Pomfret Street, Putnam, CT 06260

Assets: Please list all assets and submit copies of recent statements for each, such as:

- ❑ Savings and checking accounts
- ❑ Bonds, cash value of securities, stocks, IRA accounts, etc
- ❑ Equity in home ownership or other buildings, appraised amount (most recent property tax bill & mortgage statement)
- ❑ Ownership of land and appraised amount
- ❑ Value of automobiles, recreational vehicles, etc.

Dependents: If you list people other than family members on your application:

- ❑ Copy of the previous year's Income Tax return showing them as your dependents.

Be sure to: Before mailing in make sure that you have completed and attached the following to your application:

- ❑ Sign the application
- ❑ Include the income information and attachments
- ❑ Include an assets list (where appropriate) and attachments
- ❑ Include verification of dependents and attachments

For assistance in completing this application contact a Day Kimball Hospital
Patient Financial Counselor at 860-963-6337, Option 2
between the hours of 8:00 a.m. and 4:00 p.m. – Monday – Friday

DAY KIMBALL HEALTHCARE

APPLICATION FOR FINANCIAL ASSISTANCE PROGRAM

Date Received from Patient

Last Name:	First	Telephone Number:	
Street:	City:	State:	Zip:

List bills for which application is being made.

Name of Patient	Account Number	Date of Service	Amount Due

Please use reverse side of application for any other accounts.

Employment Income – *(Attach the supporting documentation)*

Employee Name	Employer	Date Employed from	Date Employed to	Amount Earned

Other Income per month – (Attach the supporting documentation)

Social Security: $ Pension: $			
Unemployment Compensation: $	Date From:	Date To:	
Worker's Compensation: $	Date From:	Date To:	
Veteran's Benefit: $			
Disability: $			
Alimony/Child Support: $			
Public Assistance: $	What Agency:		
Any other income: $	Source:		

List all your assets according to the attached instructions

Please check one: Rent □ Own home □	If you own your home: Real Estate Appraised Value*: $ _____ Mortgage Balance: $ _____ *based upon most recent property tax assessment	Bonds/Securities, Stocks, IRA accounts, etc: $
Savings, Checking, Cash: $		Value of secondary automobiles and recreational vehicles: $
Other:		

Dependents: List family members/or others living with you and supported by you:

Name:	Age:	Social Security Number

Please use reverse side for any additional dependents

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 also certify that the documentation of income presented with this application represents the total family income for the period of time indicated.

Signature of Applicant _____Date _____

List additional bills for which application is being made.			
Name of Patient	Account Number	Date of Service	Dollar Amount

Dependents: List additional family members/or others living with you and supported by you:		
Name:	Age:	Social Security Number

Please return documents to Day Kimball Hospital, Financial Counselors, Monday - Friday, 8:00 am - 4:00 pm; or by mail: Day Kimball Hospital, ATT Financial Counselors, 320 Pomfret Street, Putnam, CT 06260