Hartford HealthCare
Medical Group

Thank you for contacting Hartford HealthCare Medical Group, legally known as HHC PhysiciansCare Inc. regarding our Financial Assistance program. To be considered for the program, you must complete the following:

1. Complete the attached Financial Assistance Application. If a question or section is not applicable, please indicate by writing N/A.

2. Provide a copy of your most recent **Federal Tax Return**, **Proof of income for the last 90 days**, **and Bank Statements for the last 90 days**. If the supporting documents are not submitted, the application cannot be processed and may be denied.

3. Mail completed Charity Care Application and all supporting documents must be returned within 10 business days to:

   Financial Hardship Application
   Hartford Healthcare
   17 Talcott Notch, First Floor
   Farmington, CT 06032

Incomplete applications will not be processed.

Once your application is reviewed, you will be informed of the decision by mail. If you have any questions, please call 860-545-7500.

Respectfully yours,

Financial Assistance Team
Hartford Health Care

HHC PhysiciansCare, Inc.

Hartford HealthCare Medical Group

Financial Assistance Application

Patient Name:_____

Social Security No:_____-_____-_____ Account No:_____

Citizenship (check one): _____US Citizen _____Non-US Citizen

Marital Status (check one): _____Married _____Single _____Divorce ____Separated

Name of Dependents listed as dependents on tax forms or live in home and are dependents: (use back if needed)

1._____3._____

2._____4._____

Housing (check one): _____Own _____Rent House Payment $_____/month

Utilities: Electricity $_____/month Gas $_____/month Water $_____/month Phone $_____/month

Automobiles: Own (how many)____ Lease (how many) ____ Car Payment(s) $_____/month

Bank Accounts/Other Assets:

Checking $_____Balance Savings $_____Balance **(Last 90 days of statements)**

Other (Describe): _____

Employment (must check one):

Patient		Spouse	
_____	Full Time	_____	Full time
_____	Part Time	_____	Part Time
_____	Not Employed	_____	Not Employed
_____	Unable to Work	_____	Unable to Work

Total Family Income: $_____$/month **(Must send last 90 days of pay stubs for all employed members of the household)**

Other Support:

Alimony	$_____/month	Workman's comp	$_____/month
Trust Fund	$_____/month	Child Support	$_____/month
Unemployment	$_____/month	Other	$_____/month
			$_____/month

I hereby declare that the above information is true and correct. If the information supplied is inaccurate or incomplete and the patient's family income exceeds the charity guidelines, I understand that I will be responsible for payment of the entire balance of the bill. If my (our) case is selected to receive Financial Assistance, I (we) give my (our) consent to _____Medical Group to obtain information from any source to verify the statements I (we) have made available to you.

_____ _____

Signature of Applicant Date

HHC PhysiciansCare, Inc.