



APPLICATION FOR FINANCIAL ASSISTANCE

I request that The William W. Backus Hospital make a written determination of my eligibility for financial assistance. I understand that the information, which I submit concerning my annual income and family size is subject to verification by The William W. Backus Hospital. I also understand that if the information which I submit is determined to be false, such a determination will result in a denial and that I will be liable for charges of services provided.

1. NAME

Address / Town _____
 Phone _____

2. LEGAL DEPENDENTS OF APPLICANT (LIST YOURSELF FIRST)

NAME	RELATIONSHIP	DATE OF BIRTH

3. INCOME

Please list the current or most recent employer for all wage earners in the household. Provide the most recent proof of income for each earner.

Wage Earner Name	Employer	Hire Date	End Date	Hours per Week	Amount per Month (Gross)

4. OTHER SOURCES OF INCOME

Farm or Self-Employed Amount \$ _____
 Social Security Amount \$ _____
 Unemployment Compensation Amount \$ _____
 Alimony Amount \$ _____
 Child Support Amount \$ _____
 Pension Amount \$ _____
 Income from Dividends, Interest, Rent \$ _____
 Other (Type & Source) \$ _____

If you have no income please explain how you are meeting your needs

5. ORIGINATING PATIENT ACCOUNT NUMBER _____

This application applies to Backus Hospital charges **only**. It does not apply to Radiologists, Pathologists, Anesthesiologists or other professional services involved in your care that are billed separately.

The information given is true and correct to the best of my knowledge. I authorize the release of this information if it is requested.

Signature of Applicant/Guarantor: _____ Date: _____

Print Name: _____

PLEASE SEND COMPLETED APPLICATION AND ALL REQUIRED DOCUMENTATION TO:

The William W. Backus Hospital
Attn: Financial Counseling Unit
326 Washington St, Norwich, CT 06360