

1 Abrahms Boulevard West Hartford, CT 06117-1525 Tel: 860.218.2300

Admissions 860.218.2323

Fax: 860.523.3949 www.hebrewseniorcare.org

## **Hebrew Senior Care Financial Aid application instructions and Required Documents**

In order to consider you for financial assistance, the entire application must be completed and signed by you (or the responsible party). Please note that all information submitted on the form will be verified through legitimate agencies.

Please provide the following documents that apply to your household. Please submit only copies – no original documents, if applicable.

- **Copy** of Federal Income Tax Return for Self and Spouse, of the latest one you have filed, (if within the last 5 years.)

(Please send only the first two pages of your tax return – 1040 forms).

Two copies of your most recent pay stubs for self and spouse. (if within the last 12 months)

=======================================	IMPORTANT!	=======================================

Failure to submit the requested documents or providing incorrect information on the application will result in the **DENIAL** of your application leaving you responsible for the entire balance.

If you have any questions or need additional time to submit your application please call (860)523-3953.

If you prefer to send the verifications via fax; our fax number is (860) 523-3836.

Return the completed, signed application with the supporting documents to:

Hebrew Senior Care, Inc. Financial Aid Office 1 Abrahms Boulevard West Hartford, CT 06117

Original: 10/10 Updated: 8/17



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## **Patient Financial Assistance Application**

Today's Date:	Your Telephone Number:	( )		
Applicant (or parent): Last Name:	First Name:		MI:	
Social Security Number:	Date of Birth:			
Address:				
City:	State:	Zip:		
Marital Status:Married Singl	eWidowed Divorce	dS	Separated	
Background Information		Yes	No	
Do you have children under 18 who live with you?				
Are you employed?				
Do you have medical insurance?				
Are you on disability?				
Are you a veteran?				
Are you currently receiving Medicaid benefits?				
Financial Information:				
What are the amounts and sources of family income? (Include wages/salary/income from any source for				
patient and spouse or responsible party)				
Source of income		Amour	nt/Value	
Wages/Salary				
Any other income?				
Do you own any automobiles? If yes, please state gross estimated value				
Total Balance in your checking, saving, CD, or securities				

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Do you have any individual retirement accounts (IRA, 401K etc.)

Do you own or rent your home? If you own, please state current value:

Do you have other assets in US or other country? If yes, please state gross estimated value. (List all assets and value on a separate page and attach)

PAFS OFFICIAL USE ONLY – DO NOT WRITE	BELOW THIS LINE
APPLICATION RECEIVED ON:	
APPLICATION APPROVEDReason for denial:	DENIED
Hospital Representative/Management Sign	nature and Date:
	(please turn over)
	1 Abrahms Boulevard West Hartford, CT 06117-1525 Tel: 860.523.3800 Admissions 860.218.2323 Fax: 860.523.3949 www.hebrewseniorcare.org
	ne information I have provided is correct, true and complete to rmission for verification of all facts relating to my eligibility.
А	CKNOWLEDGEMENT
Patient or guarantor signature	
Witnessed by	Date
Address of above	
City	State

Original: 10/10 Updated: 8/17