Lifespan

GUIDELINES FOR FILING OF COMMUNITY FREE SERVICE APPLICATION

When filling out the Community Free Service application, please be sure to complete all areas of the form including:

- Your Date of Birth
- Your Social Security Number or Tax ID Number
- Number of dependents (include yourself, your spouse, and any children living with you, grandparents, in-laws, etc, that you claim on your Federal Income Tax)
- Annual family gross income (include income from all working family members, and income from all sources, such as unemployment, TDI, etc.) If you are not working and do not have any income, please state that in a letter along with an explanation of how your expenses are paid and who is providing support. If someone provides you with food and shelter, please send a letter from that person describing your living/income situation.

Please provide a copy of the following items that apply:

- Identification – Any of the following: a state-issued driver's license, a state-issued I.D. card, Resident Alien Card, U.S. Passport, etc.)
- Proof of Residence – Local tax or utility bill (telephone, electricity, gas or cable) addressed to you and showing your local address. If you are homeless, you may provide a statement of statement of support from any applicable shelter, church, or civic organization familiar with you and your circumstances.
- Notice of Medical Assistance or General Public Assistance denial or approval
- Copies of most recent pay stubs (for the last two consecutive pay periods) for all working family members. Please include unemployment, TDI, Social Security etc.
- Copy of last year's state or federal income tax return and any supporting W-2 Form(s). If you did not file a tax return last year you need to obtain written verification of non-filing from the IRS by contacting 1-800-829-1040.
- Copies of your most recent savings and/or checking account statements, or a copy of your recent bankbook balance. Make sure to include IRA's, money markets, CD's, etc.

If none of the above is applicable to you, please provide a signed letter explaining your circumstances.

Please mail the application and supporting documentation directly to the Patient Financial Advocate Office at the respective hospital's addresses below:

Rhode Island Hospital
Hasbro Children's Hospital
593 Eddy Street
Providence, R.I. 02903
Attn: Patient Advocate
Main Admitting

The Miriam Hospital
164 Summit Avenue
Providence, R.I. 02906
Attn: Patient Advocate

Newport Hospital
11 Friendship Street
Newport, R.I. 02840
Attn: Patient Advocate

Emma Pendleton Bradley Hospital
1011 Veterans Memorial Parkway
Riverside, R.I. 02915

Applications are usually processed within 14 days of receipt.

Thank you for your cooperation.

LIFESPAN'S APPLICATION FOR HOSPITAL FINANCIAL-AID

Any approval of this request is temporary and expires 12 months from the date of approval

Hospital:	Date:
Patient Name:	Guarantor:
Date of Birth:	Social Security #(if issued)
Social Security #(if issued):	Home Phone:
Home Phone:	Work Phone:
Work Phone:	Relation to Patient:
Home Address: Own/Rent:	Home Address: Own/Rent
Occupation & Employer:	Occupation & Employer:
Employer Address:	Employer Address:
Type of ID & #:	Type of ID & #:

Is visit related to a work injury or Accident? Yes or No - If Yes, please provide Insurance information.
(If yes, please attach explanation)

Are you being claimed as a dependent? Yes or No

Number of Dependents (including self):

Do you collect SNAP (food stamps) Yes/No if yes, please provide current letter.

Are you currently staying in a Shelter Yes/No if yes, please provide a letter from the Shelter.

Have you applied for GPA/Medical Assistance Yes or No if yes, when:

Have you applied for Social Security Disability? (SSDI) Yes/No If yes, when:

Do you have minor children? Yes/No if yes do you live with them? Yes/No

Please provide the following information for ALL members of the family unit (if they are not listed on the Federal Income Tax Form).

Name & Relationship to Patient:	SS# (if issued) &Date of Birth:
Employer, Phone & Address:	Home Address:
Name & Relationship to Patient:	SS# (if issued) &Date of Birth:
Employer, Phone & Address:	Home Address:

Monthly Income	**Assets**
Patient's Salary & Wages:	Savings:
Spouse's Salary & Wages:	Checking:
Guarantor's Salary & Wages:	Certificates of Deposit (CDs):
Child Care Income:	Money Market Accounts:
Rental Income:	Saving Bonds:
Unemployment Compensation:	Stocks:
Temporary Disability Insurance:	Bonds:
Child Support:	Mutual Funds:
Alimony:	IRAs:
Workers' Compensation:	401(k)s:
VA Benefits:	403(b)s:
Social Security Payments:	457s:
Dividend & Interest Income:	Cash-In Value Life Insurance:
Royalties:	Personal Property:
Pensions:	2nd Home & Rental Property:

Monthly Income Cont.:	**Assets Cont:**
Public Assistance:	2nd Motor Vehicle:
Other:	Total:
Monthly Income:	
Annual Income:	Total Monthly Expenses:
IF YOU LIST NO INCOME WHAT HAS BEEN YOUR SOURCE OF SUPPORT? Use separate sheet of paper if needed.	

Please be sure to enclose a copy of your most recent Federal Income Tax Filing and the last two paycheck stubs.

"I request the hospital to make a determination of eligibility for financial aid. I understand that this information is confidential and subject to verification by the hospital. I also understand that if the information I provide is false, I may be denied financial aid and be liable for payment for the hospital services provided. I hereby attest that the information in this application is complete and correct to the best of my knowledge and that I understand the process and my responsibilities."	
Signature:	Date:

Action Taken By The Hospital

CHECK OFF LIST

Pay Stubs_____ **Food Stamp Letter_____** **Tax Returns_____**

Credit Report_____ **Other Documentation_____** **Date verified with E.D.S/GPA_____**

If non-resident required documentation:_____

Date:_____ **Not Approved:_____** **Reason:_____**

Approved:_____ **Account #:_____** **Expiration Date:_____**

Comments:_____
_____
_____
_____

_____ _____

Authorized Signature Administrative Approval