



Lifespan

Community Free Service Application Directions

When completing the Community Free Service Application, please fill in **all** areas including:

- Number of dependents. That includes yourself, spouse and any children living with you that you claim on your federal income tax.
- Weekly or monthly gross earned income, unemployment, temporary disability insurance (TDI), etc. If you do not have any income, please send a **notarized, written explanation** as to how your expenses are paid or who is providing support.
- Social Security number or Resident Alien number
- Date of birth
- Please remember to sign the application

Forms Needed to Apply

- AFDC, Medial Assistance or GPA acceptance or denial letter.
- Last years' income tax return. If none was filed, then you need to call the IRS at **1-800-829-1040** and request letter #1722, which states you did not file any taxes.
- Your most recent three pay stubs, unemployment, TDI, etc.
- Your most recent savings and/or checking bank statements including: IRA's, money markets, CD's or a copy of your bankbook balance.

You will be notified of the outcome of this application within approximately three weeks from the date the application is received in our office.

Please note:

- Physician, radiologist, pharmacy or anesthesiologist bills that you have cannot be included for consideration. These are your responsibility to pay.
- Should you have any "Collection Agency" bills please contact that agency to discuss payment of these bills.

Thank you for your anticipated cooperation.

Please mail your application and attachments to: Lifespan

Patient Financial Services
The CORO Building
167 Point Street
Providence, RI 02903



Lifespan

HOSPITAL: _____ **DATE OF APPLICATION:** _____

Patient's Name: _____ (First)
(Middle) (Last)

Date of Birth: _____ Social Security #: _____/_____/_____ Is visit related to work
injury or accident? _____ Yes _____ No (If yes, please attach explanation) Are you being claimed as a
dependent? _____ Yes _____ No

Parent(s)/Guarantor Name: _____ (First)
(Middle) (Last) Date of Birth: _____ Social Security #: _____/_____/_____
Address: _____ City: _____ Apt# _____

State: _____ Zip: _____ Telephone#: (____) _____ - _____ Own/Rent: _____

No. of dependents (including yourself) _____ Type of I.D. and # _____

Annual Family Income: (Please enter dollar amount for each listed below)

Patient's Gross Income: \$ _____ Spouse's Gross Income: \$ _____ Guarantor's Gross Income:
\$ _____ Saving's/checking: \$ _____ Rental Income: \$ _____ Child Support: \$ _____

Alimony: \$ _____ Food Stamps: \$ _____ Pensions: \$ _____

Other: \$ _____ Total monthly expenses: \$ _____ Total family income: \$ _____

Please be sure to enclose a copy of your most recent federal income tax filing and a recent paycheck stub.

The foregoing information is for the purpose of eligibility of the above named patient to receive full or partial Community Free Service and is true to the best of my knowledge and belief. I hereby agree to furnish necessary information and authorize the Lifespan affiliate to verify any and all information presented. If for any reason, the above information is found to be false, this application will automatically be denied. I also understand that this application is for hospital services only and does not include the fees for physicians, radiologists and anesthesiologists.

Applicant's Signature (Date) Witness

Action Taken by Hospital for CURRENT SERVICE(s)

CHECK OFF LIST Pay stub: _____ Food Stamp Letter: _____ Tax Returns: _____
Credit report: _____ Other Documentation: _____ Date Verified with E.D.S./GPA _____

Date: _____ Not Approved: _____ Reason: _____

Approved: _____ Account# _____ Expiration Date: _____

Signature Administrative Approval _____

Authorized