Connecticut Children's Financial Assistance Application

Dear Parent(s) or Guardian(s):

Thank you for choosing Connecticut Children's for your child's health care needs.

To apply for financial assistance, please submit the completed application and all supplemental information. Verification of income is **required** in order to process this application. Verification of income can include:

- Federal Tax Returns (1040) for the past year.
- W-2(s)
- One month worth of paycheck stubs (last 4 if paid weekly/Last 2 if paid bi-weekly)
- Letter of financial support from the person that is financially supporting you/your family.
- Proof of Unemployment Wages Letter
- Child Support/Alimony Statement
- Social Security/SSI Statement

Our Financial Counselors are available should you require assistance with the application process.

Phone: 860-545-8086
Text: 860-891-2726
Fax: 860-545-9057
Email: FinCounselors@connecticutchildrens.org
Location: 282 Washington St. – 2C | Hartford, CT

Please send the completed application and supporting documentation to the email above. We will confirm receipt and notify you of next steps within 72 business hours.

Sincerely,

Connecticut Children's Financial Counseling Team

FINANCIAL ASSISTANCE APPLICATION

Patient's Name:	**Guarantor's Name:**
Patient Medical Record Number:	**Guarantor Number:**
Patient's Date of Birth:	**Guarantor's Date of Birth:**
Address: (street name – city, state, zip code)	**Address:** (street name – city, state, zip code)

Household Size – Include parents/legal guardians, step parents and siblings/dependents
(Must be able to provide proof of dependency if asked)

Name	Date of Birth	Relationship to Patient
1.		
2.		
3.		
4.		
5.		
6.		
7.		
Total Persons in Household		

Income Information – Include all sources of income for everyone in the household.
(Include all income from employment, child support/alimony, Social Security, SSI, Unemployment, etc.
Submit all proof for income reported below along with this application).

Name	Income Source	Amount	Frequency (weekly, bi-weekly, monthly, annual)
		$	
		$	
		$	
		$	
	Total	$	

Incomplete or fraudulent applications will be denied.
In completing this financial statement, I hereby affirm that the above statements are correct and complete, and I give my consent for further verification by Connecticut Children's and/or its representatives.

Signature/Date: _____/_____

Relationship to patient: _____