Advanced Radiology℠

Thank you for inquiring about our Charity Care program. In order to expedite the processing of your application, please provide the information requested below. Please remove or black out any Social Security and/or account numbers on all documents. Do not send any original forms/documentation. All submitted paperwork is scanned to a secure server and shredded. Forms will not be returned. If you have any questions, or need additional information, please call 203.696.3692.

REQUIRED INFORMATION/DOCUMENTATION:

- Completed and signed Charity Care Application (enclosed).
- Copies of the following:
  - Any state or governmental program letters awarding benefits or assistance (Medicaid, Veteran's Benefits, Social Security, etc.).
  - Three (3) months of documentation to support:

    Family Income: For example, previous year's tax forms, employment pay stubs, other means of income such as social security, pension, unemployment, alimony, interest, dividends, rental income, or other income received for both patient/responsible party and spouse/partner.

    Family Expenses: For example, living expenses, rent, mortgage, utilities, car loan, medical bills, credit cards, or other expenses.
- If you have no income, a letter with a date and signature from the person who is financially supporting you (providing food, shelter, and assisting with bills) to demonstrate that there is no income.

Please return the signed application along with supporting documents in the return envelope or by fax (203-337-9731) within fifteen (15) business days. If you need assistance completing the application, please contact us at the telephone number provided below.

Respectfully,

Revenue Cycle Manager

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CHARITY CARE APPLICATION

Form must be COMPLETELY filled out - PLEASE PRINT

Date _____

Applicant Name (First, Middle Initial, Last) _____

Mailing Address _____ City _____ State _____ Zip _____

Home Address _____ City _____ State _____ Zip _____

○ Same as Mailing Address

Patient Name (First, Middle Initial, Last) _____

Date of Birth _____

Preferred Contact: ○ Phone _____ ○ Email _____

How long have you lived at your current residence? _____

Are you currently living in a shelter? ○ Yes ○ No

Shelter Name _____

Shelter Address _____

Residency Status (Please check one):

○ U.S. Citizen ○ Permanent Resident of the U.S. ○ Temporary Worker Visa

○ U.S. Visitor ○ Academic Documented Student

○ Other (please specify) _____

○ Undocumented Resident (specify place of birth) _____

Are you a U.S. Veteran? ○ Yes ○ No If yes, are you a WWII Veteran? ○ Yes ○ No

Are you currently employed? ○ Yes ○ No

Name of current employer _____

Length of employment _____

Are you married or related by civil union? ○ Yes ○ No

Name of spouse/partner _____

Spouse's/partner's employer _____

Have you applied for State Medical Assistance? ○ Yes ○ No

Date of application _____

Case number _____

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CHARITY CARE APPLICATION

Number of Dependents: _____ (A dependent is a person listed as a dependent on the patient's tax return.)

List all dependents below:

Name of dependent	Relationship	Date of Birth	Age

Proof of Income Information (If applicable)

Source of Income	Patient/Responsible Party (Enter amount per month)	Spouse / Partner (Enter amount per month)	Other Contributor (Enter amount per month)
Gross Wages/Earnings (Before taxes)			
Other Individual			
Child Support/Alimony			
Disability Benefits			
Pension Benefits			
Rental Income			
Self-Employment or Farm Earnings			
Social Security Benefits			
Trust Fund/Inheritance			
Unemployment Benefits			
Workman's Compensation			
Other Income (please specify; e.g. Dividends, Interest, Stocks, Pending Settlements, Other Assets, etc.)			
TOTAL INCOME			

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CHARITY CARE APPLICATION

Expense Information

Expense	Monthly Payment	Outstanding Balance
Mortgage / Rent		
Auto Loan / Lease		
Credit Cards		
Medical		
Utilities (Gas, Oil, Electric, Water, Phone)		
Other (please specify):		

Please select any of the following programs in which you currently participate or are eligible for:

- ⬭ SNAP (Food Stamps)
- ⬭ Subsidized School Lunch Program
- ⬭ WIC (Women, Infants, and Children)
- ⬭ Subsidized Housing or other Public Assistance
- ⬭ State-Funded Prescription Drug Program

To complete this determination, please provide a letter that indicates you have been approved for, or denied, State Medical Assistance, along with one of the following:

- Three (3) months of documentation to support the income listed on this application
- A Letter of Support from the person who is financially supporting you

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The above statements are true and accurate to the best of my knowledge. I understand that available funds are used only after all other sources of third party payment have been exhausted. I agree to cooperate and follow through with an application for State Medical Assistance as well as follow up or provide any other Third Party Payer documentation, as requested.

Applicant Signature _____ Date _____

Application Received By: _____ Date _____

Comments:

Mail this application to:
Advanced Radiology Partners, LLC
1 Corporate Drive, Suite 325
Shelton, CT 06484

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CHARITY CARE APPLICATION

FOR OFFICE USE ONLY

Account information (For Staff Use Only)

Account Number	Date of Service	Patient Balance Due

Approved ○ Full ○ Partial_____ %

○ Denied Reason: _____

_____

_____

Medical Record Number (MRN): _____

Account Number _____

Reviewed by _____

Title _____

Signature _____

Date _____