

## Community Health & Wellness Center Financial Assistance

Welcome to Community Health & Wellness Center's Comprehensive health care services. We appreciate that you have chosen our center for health care and look forward to working with you to meet your health care goals.

It is the goal of CHWC to diminish as much as possible, any financial barriers to receive health care services.

Financial support is available. A schedule of discounts is available based on the federal poverty guidelines to those who qualify.

Patients are encouraged to make an appointment to apply for Medicaid medical insurance with the DSS Eligibility/Financial Counselor at CHWC or by calling 860-489-0931 extension 157.

If you are not eligible for Medicaid medical insurance you will need to fill out a Financial Assistance application to see if you qualify for a discounted rate on your bill.

**Verification of income must be provided to determine if a patient qualifies for discounted services.**

Below is a list of documentation that our financial counselors use to determine if you qualify for assistance.

**Please include all the necessary documentation that verifies your household's Gross Monthly Income, such as:**

- A month's worth of pay stubs
- Bank Statement
- Most recent Tax Return, W-2 or 1099
- Social Security (Retirement or Disability) or SSI income
- Letter from Employer (for undocumented immigrants only)
- Other income: alimony/child support/unemployment compensation/pension/IRA/rental income, etc.

**\*\*\*\*A yearly renewal is required unless changes to your income occur sooner\*\*\*\***

### **IMPORTANT:**

**You are expected to pay at least \$25.00 at each appointment. This amount will be applied to your bill until financial assistance is determined. Once the discounted rate is established, your reduced rate is expected on the day of service, unless other arrangements are made in advance with our Financial Counselor.**

**Failure to provide proof of income within 30 days of your first visit will result in a bill for services rendered at full rate. We will assume financial assistance is not needed.**

### **Please note:**

**\*\*\*\*Financial Assistance applies to medical, dental and behavioral health services provided by Community Health & Wellness only. You will receive separate bills for any off site services provided by other facilities. Ex: labs, x-rays, specialty care, etc.**

### **NOT COVERED UNDER FINANCIAL ASSISTANCE:**

**\*\*\*\*Blood draws done by Charlotte Hungerford Hospital tech at Community Health & Wellness Center are not covered under your financial assistance.**

**\*\*\*\*Dental Lab Fees are not covered under your financial assistance. All dental lab fees are due before these services are rendered.**

**Community Health & Wellness Center  
Confidential Patient Financial Statement**

Social Security#:		DOB:	
Name:			
Address:			
City:	State:	Zip Code:	
<b>GROSS monthly income: \$</b>			

Provide us with the best phone number we should use to call you:

Home Phone:	Cell Phone:
-------------	-------------

Marital Status: single married divorced widowed	Number of people living with you:
---	-----------------------------------

**Please list family members and/or people that live in your household and their income:**

Name:	Name:
DOB:	DOB:
Relationship to patient:	Relationship to patient:
<b>GROSS Monthly Income:</b>	<b>GROSS Monthly Income:</b>

Name:	Name:
DOB:	DOB:
Relationship to patient:	Relationship to patient:
<b>GROSS Monthly Income:</b>	<b>GROSS Monthly Income:</b>

**(Please use attached sheet for additional family member information)**

**I understand that if the financial information that I have provided is found to be falsified or untrue, that the financial assistance will immediately be revoked and I will assume full responsibility for all my services rendered at CHWC of Greater Torrington.**

***I CERTIFY THAT THE ABOVE INFORMATION IS ACCURATE AND THAT ALL HOUSEHOLD INCOME HAS BEEN LISTED ABOVE.***

Patient's Signature:	Date:
----------------------	-------

Name:
DOB:
Relationship to patient:
GROSS Monthly Income:

Name:
DOB:
Relationship to patient:
GROSS Monthly Income:

Name:
DOB:
Relationship to patient:
GROSS Monthly Income:

Name:
DOB:
Relationship to patient:
GROSS Monthly Income:

Name:
DOB:
Relationship to patient:
GROSS Monthly Income:

Name:
DOB:
Relationship to patient:
GROSS Monthly Income: