Form Revision Date: March 2025

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 monthly expenses, (Heat, Rent, food, Utilities, etc.)

- 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.

Brown University Health's Patient Financial Advocates (PFA) are available for assistance with completing the application. the Patient/patient's family may either schedule an appointment, or walk-in to see an advocate at any location below. Patients can also receive assistance information by calling the PFA's at (401-444-7850. For inquiries from Massachusetts Hospitals, please call the number at the hospital below.

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 ATTN: Patient Advocate APC Basement/HIS Dept. 593 Eddy Street Providence, RI 02903	The Miriam Hospital ATTN: Patient Advocate 164 Summit Ave Providence, RI, 020906	Newport Hospital ATTN: Patient Advocate 20 Powell Street Newport, RI, 02840
Emma Pendleton Bradley Hospital ATTN: Financial Counselors 1011 Veterans Memorial Parkway Riverside, RI 02915	Saint Anne's Hospital ATTN: Financial Counselors 795 Middle St Fall River, MA 02721 (508) 235-5029	Morton Hospital ATTN: Financial Counselors 88 Washington St Taunton, MA, 02780 (508) 508-828-7324

Applications are usually processed within 14 days of receipt.

Thank you for your cooperation.

BROWN UNIVERSITY HEALTH HOSPITALS AND AFFILIATE FINANCIAL ASSISTANCE APPLICATION

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

Brown University Health Hospitals and Affiliates Date:

Patient:	Guarantor/Spouse:
MR#:	MR#:
Date of Birth:	Date of Birth:
Social Security # (if issued):	Social Security # (if issued):
Home Phone: Cell Phone:	Home Phone: Cell Phone:
Home Address:	Relation to Patient:
	Home Address:
Own/Rent?	
Occupation & Employer:	Occupation & Employer:
Employer Address:	Employer Address:

Is this visit related to a work injury or accident? Yes No (if yes, please provide insurance information and attach explanation)

Are you being claimed as a dependent? Yes No Number of Dependents (including self):

Do you collect SNAP benefits? Yes No If yes, provide current letter Are you living in a shelter? Yes No If yes, provide a letter from shelter

Have you applied to HealthSource RI? Yes No please provide letter Have you applied for Social Security Disability? (SSDI) Yes No (if yes, when)

Please provide the following information for ALL members of the family unit, EXCEPT the Patient or Guarantor.

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

MONTHLY INCOME	AMT	ASSETS	AMT	MONTHLY EXPENSES/LIABILITIES	AMT
Patient's Salary & Wages		Savings		Mortgage or Rent Payment	
Spouse's Salary & Wages		Checking		Current Balance _____	
Guarantor's Salary & Wages		Certificates of Deposit (CDs)		Property Taxes if not included in mortgage payment	
Self-Employment Income		Money Market Accounts		Utilities: Gas/Electric/Oil _____	
Child Care Income		Savings Bonds		Cable/Internet _____	
Rental Income		Stocks		Phone _____	
Unemployment Compensation		Bonds		Auto Payments or Lease Payments	
Temporary Disability Insurance		Mutual Funds		Current Balance _____	
Child Support		IRAs		Credit Card Payments	
Alimony		401(k)s		Current Balance _____	
VA Benefits		403(b)s		Installment Loans	
Social Security Payments		457s		Current Balance _____	
Dividend & Interest Income		Cash-In Value Life Insurance		Auto Insurance	
Royalties		Personal Property		Homeowners/ Renters Insurance	
Pensions		2nd Home & Rental Property		Medical Expenses	
Public Assistance (*include SNAP if receiving*)		Additional Motor Vehicles		Groceries	
Other				Other Expenses	
MONTHLY INCOME:					
ANNUAL INCOME:		**TOTAL:**		**TOTAL:**	

"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."

Patient's Signature: _____ Date: _____

Spouse/Guarantor Signature: _____ Date: _____

FOR INTERNAL PURPOSES ONLY

Approved By: _____ Date: _____

Denied By: _____ Date: _____

Manager Signature: _____ Medical Assistance: ❒ Yes ❒ No

Insurance Coverage: _____

Comments: _____

_____

Family Size: _____ FPL Level: _____ %FPL: _____

DISCOUNT (%): _____ Date Range: _____