EXHIBIT F

MILFORD REGIONAL MEDICAL CENTER
NOTICE OF DENIAL

Date:

Applicant:

List of Family Members:
Name: _____ MR# _____
Name: _____ MR# _____
Name: _____ MR# _____
Name: _____ MR# _____

Dear:

Milford Regional Medical Center has conducted an eligibility determination for its Financial Assistance Program. Based on the information supplied by the applicant, the following determination has been made:

DENIAL:

_____ Your request for financial assistance has been denied because:
_____ You did not qualify due to the income guidelines –
Income for the household is $_____ and the guideline limit is $_____

_____ Incomplete Application or Missing Documentation

You have the right to reapply for the Financial Assistance Program in the future or if your financial situation changes, but you will need to have a current account balance to reapply.

Accounts in Bad Debt Collection status do NOT qualify for coverage under this program.

If you would like to set up a payment arrangement on your balances, please contact our office at _____.

If you have any questions regarding this determination, please call the Patient Financial Services Department at _____ for assistance.