EXHIBIT C

MILFORD REGIONAL MEDICAL CENTER

RETURN OR DEFERRAL OF APPLICATION

Date: _____

Patient: _____

Re: Financial Assistance Application Received on _____

Thank you for submitting in your application for the Financial Assistance Program. Unfortunately, we have to defer approval of your application at this time because the application is incomplete.

COMPLETED APPLICATION MUST BE RETURNED WITHIN TEN (10) DAYS.

Check marks have been put in front of the items needed in order to process your application:

_____ Most recent pay stubs for each employed member of family with YTD gross income.
_____ Most recent 4 weeks of pay stubs if it does not include YTD gross income.
_____ For applications submitted in April or later, Self-Employed/Rental Income needs to include work ledger for January to present.
_____ For applications submitted between January and March, Self-Employed/Rental Income needs to include work ledger for the entire previous year or the Tax Schedule C filed for the previous year.
_____ Social security benefits letter(s) for this year showing monthly income.
_____ Proof of all Retirement/Pension Income for this year.
_____ Proof of all Unemployment Compensation for this year.
_____ Proof of all Other Forms of Income for this year.
_____ Foster or guardian children need court order and proof of income received.
_____ Copy of last year's Tax Return or W2's and 1099's for Social Security (all pages).
_____ Copy of most recent filed Tax Schedule C for Self-Employed/Rental Income.
_____ Copy of application for insurance on the Health Insurance Exchange.
_____ Copy of State issued Driver's License of Photo ID Card.
_____ All lines on the form must be completed. If a line does not apply to you, please put a line through it so that we know you have not overlooked it.
_____ Signature and date for both applicant and co-applicant, if applicable.

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Please provide us with an explanation of the following:

_____ You are 65 or over and do not show social security income.

_____ You are disable and do not show disability income or other medical assistance income.

_____ You are in a category which often receives medical assistance income.

_____ You are reporting no income, please explain how you are paying for food, shelter and utilities.

_____ Other: _____

Explanation:

_____
_____
_____
_____
_____

MAKE SURE YOU RETURN EVERYTHING YOU SENT ORIGINALLY ALONG WITH THE INFORMATION REQUESTED ABOVE AND REDATE THE APPLICATION AS OF THE DATE THAT YOU REMAIL IT.

When this information is received, your application can be processed. Thank you for your prompt attention to this matter. If you have any questions, please call our Patient Financial Services Department at

_____.