EXHIBIT D

MILFORD REGIONAL MEDICAL CENTER

DETERMINATION OF ELIGIBILITY FOR FINANCIAL ASSISTANCE PROGRAM
OFFICE USE ONLY

Date: _____

Name: _____
First Middle Last

Address: _____

Other Family Members: Name: _____ MR# _____
Name: _____ MR# _____
Name: _____ MR# _____
Name: _____ MR# _____

Request for Determination of Eligibility Attached.

Income Guidelines: Total Income for Last 3 Months: $_____ x4 = $_____
Total Income for Last 12 Months: $_____
_____ Does not meet eligibility criteria
_____ Meets eligibility criteria
_____ Free Care
_____ Discounted Care

The applicant is:
_____ Eligible Category: _____
Effective Date: _____ Six Month Expiration Date: _____
_____ Not Eligible
_____ Deferred

Explanation of Non-Acceptance: _____

Date Deferral Notice Sent: _____

Prepared by: _____ Date: _____

Approved by: _____ Date: _____