EXHIBIT E

MILFORD REGIONAL MEDICAL CENTER
NOTICE OF APPROVAL

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:

APPROVAL:

_____ Your request for financial assistance has been approved for:
_____ Free Care
_____ Discounted Care

Effective Dates: _____ to _____

A listing of accounts being written off under this program is attached.

Note that income must be revalidated for each inpatient admission.

This is NOT an insurance. It is an income-based financial assistance program.

This program only covers medically necessary services.

This program does NOT cover liability or MVA situations.

This program does NOT cover accounts which have previously been sent to a Bad Debt Collection Agency.

Accounts covered under this program are NOT eligible for any other discounting opportunities, including prompt payment discounts.

You have the right to reapply for financial assistance 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 qualify for coverage under this program up to 240 days from the first post-discharge billing statement.

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