Roger Williams
MEDICAL CENTER
825 Chalkstone Ave
Providence RI 02908
401-456-2000

RE: APPLICATION FOR COMMUNITY FREE CARE PROGRAM

You have received an application form for the Community Free Care Program at Roger Williams Medical Center.

In order to be considered for this program, please complete this application to the best of your ability.
Missing information could cause a delay in the application process, so please be as complete as possible.

Along with the completed application form, you must provide PROOF OF INCOME.
Proof of Income includes, but is not limited to, copies of your payroll check stub, or copies of your Social Security check or award letter, or copies of your unemployment check or award letter, or copies of the most recent years 1040 Income Tax Return Form that you have completed.

If you do not have a source of income, please be sure to sign the ZERO INCOME DECLARATION located at the bottom of this cover letter and return this with your completed application.
Be sure to sign and date the authorization section at the bottom of the application page.

If you have any questions about the application form, or if you need assistance in completing the application please call the Patient Financial Services Office at 401-456-2410.

You will be notified of our decision by mail within 14 days of the receipt of your completed application.
Thank you.

ZERO INCOME DECLARATION

I, ____, am currently unemployed and have zero income. I have not worked for _______________years and I have not filed an income tax return since _________. My social security number is:_______________________
I hereby certify that the above information is true and accurate and understand that the hospital will investigate if deemed necessary.