

## Financial Assistance Application

1. Fatient 5 millionnation	1.	Patient's	Information
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Last Name			First Name		Middle Initial	Social Securit	y Number	Date of Birth	
Street Addres	55			City		State		Zip Code	
Mailing Addro	ess			City		State		Zip Code	
Home Phone	Number			Other Phone	Number		-		
<u>Marital Statu</u>	s (circle one):					<u>Citizenship St</u>	<u>atus (circle c</u>	one):	
Single	Married	Civil Union	Separated	Divorced	Widowed	U.S. Citizen	VT Resident	NH Resident	
2. Person F	Responsible	for Paying t	he Bill						
Last Name			First Name		Middle Initial	Social Securit	y Number	Date of Birth	
Street Addres	SS			City		State		Zip Code	
3. Househo	old Informat	ion							
		le living in the				onal sheet of paper if ne			
Name			Relationship	to Patient	Date of Birth	Social Securit	:y #	Applying for assis	
<u>1.</u> 2.									/ NO / NO
3.									/ NO
	lication for futu	ure or past ser	vices? (circle)	FUTURE / PAS	ят			125	7110
	ne in your hou								
	, Health Insura			, ,					
	Policy / ID #:								
	Health Saving	s Account? (ci	rcle) <b>YES / NO</b>						
C. Has anyon	e in your house	ehold applied	for Medicaid?	(circle) YES / I	NO				
D. Have you a	applied for fina	ncial assistand	e at another f	acility? (circle)	) <b>YES / NO</b> If y <u>es, w</u>	vhere?			
E. Is anyone i	n your househ	old pregnant?	(circle) YES / I	NO					
F. Has anyone	e in your house	ehold served in	n the military?	(circle) YES /	NO				
G. Have you	recently filed a	workers' com	pensation or r	notor vehicle	accident claim? (cire	cle) <b>YES / NO</b> If yes, wh	ien:		
H. Is anyone i	in your househ	old eligible fo	r Social Securit	ty Benefits? (ci	ircle) <b>YES / NO</b>				
I. Does anyor	ne in the house	hold pay child	support? (circ	cle) YES / NO	If yes, monthly amo	ount paid:			
J. Does anyor	ne else claim yo	ou on their inc	ome tax retur	n? (circle) <b>YES</b>	<b>/ NO</b> If yes, who:				
K. Are there a	any adults in th	e household v	vho do not hav	ve any income	? (circle) YES / NO	If yes, who:			
L. Are there a	iny adults in th	e household v	/ho do not hav	ve any bank ac	counts? (circle) YES	/NO If yes, who:			



## 4. Household Income Information

	Person 1	Person 2	Person 3
Name of each household member:			
lame of your employer:			
Gross Monthly Income from:			
Employment:			
Self-Employment:			
Investment Accounts:			
Real-Estate rentals:			
Unemployment:			
Retirement:			
(Social Security, pension, annuities)			
Alimony / Child Support:			
Other income:			
avings and Investments:			
Checking Account Balances:			
Savings & CD Account Balances:			
IRA, 401k, 403b Balances:			
Other savings & investments:			
)ther:			
Automobile (Year, Make, Model)			
Recreational Vehicle (Year, Make Model)			

## 5. Household Expenses

Do you own property other than your primary residence? (circle) YES / NO If yes, additional information may be requested

Monthly Rent Payment:

Monthly Mortage Payment:

Medicare Part B, Part C, or Part D deducted from Social Security Check: \_\_\_\_\_

## 6. Assignment of Rights (Read Carefully)

By signing below I authorize the request for my credit report and/or tax return. I understand that a tax return is needed to process this application and that more information may be requested before my eligibility can be determined.

In the event that I have not fully disclosed, or have inaccurately represented, any income or assets, any agreement to provide you with a charitable care discount would be null and void and would be retroactive back to the date the bills were owed. I may be liable for any/all legal fees during the collection process.

All adult household members who sign below authorize the release of any medical, financial or employment information which relates directly to their health care or to their financial assistance eligibility. This information may be released to any health care providers from whom household members have sought health care services or financial assistance. All information provided will remain confidential under the provisions of HIPAA federal regulations. Elective procedures might not be considered for assistance.

I agree that I will repay the full financial assistance award if I receive payment of any kind for the medical services covered by this application, for example insurance payments, government program payments, award from a lawsuit or any other payment.

If I receive Financial Assistance, I agree to tell the organization where I first applied of any changes which could impact eligibility, including changes to family size, income and health insurance coverage. I understand that if my/our medical situation changes so that I/we might be eligible for a public assistance program, I will need to apply to that program and provide proof of application.