# Financial Assistance Application

NCH north country healthcare | Weeks Medical Center

## 1. Patient's Information

Last Name | First Name | Middle Initial | Date of Birth

Street Address | City | State | Zip Code

Mailing Address | City | State | Zip Code

Home Phone Number | Other Phone Number

Residency: please circle one

| VT Resident | NH Resident | ME Resisent | Other | | |
|---|---|---|---|---|---|

| | | | |
|---|---|---|---|

## 2. Person Responsible for Paying the Bill

Last Name | First Name | Middle Initial | Date of Birth

Street Address | City | State | Zip Code

## 3. Household Information

** Please indicate ALL people living in the household, including the applicant: (Use additional sheet of paper if needed)

| Name | Relationship to Patient | Date of Birth | Applying for assistance? |
|---|---|---|---|
| 1. | | | YES / NO |
| 2. | | | YES / NO |
| 3. | | | YES / NO |

A. Is this application for future or past services? (circle) **FUTURE / PAST**

B. Have you applied for financial assistance at another NCH facility? (circle) **YES / NO** If yes, where?

C. Do you currently have or have you applied for any other insurance coverage? (circle) **YES / NO** If yes, please explain:

D. Does anyone in the household pay child support? (circle) **YES / NO** If yes, monthly amount paid:

E. Does anyone else claim you on their income tax return? (circle) **YES / NO** If yes, who:

F. Are there any adults in the household who do not have any income? (circle) **YES / NO** If yes, who:

## 4. Household Income Information

| | Person 1 | Person 2 | Person 3 |
|---|---|---|---|
| Name of each household member: | | | |
| Name 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: | | | |

## 5. Assignment of Rights *(Read Carefully)*

By signing below I authorize the request for my 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 insurance coverage, I will be encouraged to apply.

**Applicant Signature** **Date**

**Co-Applicant Signature** **Date**