



# Mt. Ascutney Hospital and Health Center

Dartmouth-Hitchcock

## FINANCIAL ASSISTANCE -- CONFIDENTIAL FINANCIAL STATEMENT

1. Patient's name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Phone # \_\_\_\_\_ Email Address \_\_\_\_\_  
Patient's address \_\_\_\_\_
2. Person responsible for payment of bill and address if different from above  
\_\_\_\_\_
3. Do you have health/medical insurance? Yes \_\_\_ No \_\_\_ Name of insurance \_\_\_\_\_  
Subscriber Name and ID \_\_\_\_\_  
Effective Date of Policy \_\_\_\_\_
4. Have you recently filed a worker' compensation or motor vehicle accident claim associated with unpaid bills at MAH? Yes \_\_\_ No \_\_\_
5. Do you own a home used as your primary residence? Yes \_\_\_ No \_\_\_ Do you rent? Yes \_\_\_ No \_\_\_  
Mortgage or Rent Amt\$ \_\_\_\_\_  
Year Purchased \_\_\_\_\_ Amount owed\$ \_\_\_\_\_ Value\$ \_\_\_\_\_ Yearly Taxes \_\_\_\_\_  
Do you own other residential or non-residential property? Yes \_\_\_ No \_\_\_  
Year Purchased \_\_\_\_\_ Amount owed\$ \_\_\_\_\_ Value\$ \_\_\_\_\_ Yearly Taxes\$ \_\_\_\_\_
6. List all savings, checking accounts, alimony, IRA's, stocks, bonds, 401ks, mutual funds and certificate of deposits  
Type of account \_\_\_\_\_ Amount \$ \_\_\_\_\_  
Type of account \_\_\_\_\_ Amount \$ \_\_\_\_\_  
**Please provide a complete copy of your most recent bank statement, we are unable to process your application without your latest bank statement.**
7. If you receive monthly income that **is not directly deposited, we will need to see a copy of that benefit/payment.** Ex: Social Security, disability, retirement, alimony, rental income, unemployment compensation, or from friends/relatives.  
Type of income \_\_\_\_\_ Monthly Amount\$ \_\_\_\_\_  
Type of income \_\_\_\_\_ Monthly Amount\$ \_\_\_\_\_
8. If currently unemployed, last day of work \_\_\_\_\_ When do you expect to return back to work? \_\_\_\_\_

9. List or attach list of all vehicles (including recreational vehicles) owned by you or your dependents and indicate monthly payments.

Make \_\_\_\_\_ Year \_\_\_\_\_ Monthly Payment \$ \_\_\_\_\_ Balance Due \$ \_\_\_\_\_  
Make \_\_\_\_\_ Year \_\_\_\_\_ Monthly Payment \$ \_\_\_\_\_ Balance Due \$ \_\_\_\_\_

10. Please provide information on the following monthly expenses:

<u>Monthly Expense</u>	<u>Monthly Payment</u>	<u>Unpaid Balance</u>
Living(gas,food,clothes)	\$ _____	\$ _____
Utilities (phone,electric etc)	\$ _____	\$ _____
Heating/gas/wood/propane	\$ _____	\$ _____
Insurance(Auto/Life/Property)	\$ _____	\$ _____
Other	\$ _____	\$ _____
Alimony/Child Support	\$ _____	\$ _____
Health Insurance	\$ _____	\$ _____
Childcare	\$ _____	\$ _____
Healthcare Bills/Prescriptions	\$ _____	\$ _____

11. List other debts. /expenses not listed above (school loan, bank/personal loans, credit cards, etc.)

<u>Name of Company</u>	<u>Monthly Payment</u>	<u>Balance Due</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

12. If you have no income, please write below how you are meeting monthly expenses:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

13. Please indicate the phone number and best time to contact you if additional information is needed or your email address:

Phone \_\_\_\_\_ Time \_\_\_\_\_ Email \_\_\_\_\_

14. What monthly payment would you be able to make toward your Hospital/Physician bill? \$ \_\_\_\_\_
15. Are you claimed as a dependent on anyone's latest filed tax return?

(Parent, Guardian, Spouse, Partner, Other)  
Yes \_\_\_\_\_ No \_\_\_\_\_

**If you answered yes to question 15, we will need a copy of the latest filed tax return from the person who claims you as a dependent.**

**Please attach a complete copy of your latest filed Federal Income Tax Return.** If you do not have a copy of this return, please contact the I.R.S. at 800-829-1040 for a free transcript. We are unable to process your application without your latest filed tax return.

**If you do not file a tax return, please list the reason why:**

\_\_\_\_\_  
\_\_\_\_\_

Any questions, please contact a Financial Counselor at 802-674-7471 or WCHC at 802-674-7213

Receive in-person assistance by going to the following locations  
Mt Ascutney Hospital and Health Center 289 County Road Windsor, VT  
Ottauquechee Health Center 32 Pleasant Street Woodstock, VT  
Mt Ascutney Hospital Ophthalmology 80 S. Main Street Hanover, NH

**Please return form to: Mt. Ascutney Hospital, 289 County Rd. Windsor, VT 05089**

**ATTN: Customer Service Department**

**Additional Copies found at [www.mtascutneyhospital.org](http://www.mtascutneyhospital.org)**

**If you do not hear from us in 30 Days, please contact us at 802-674-7471.**

**(Please DO NOT FAX this application, as your information is confidential)**

**Thank you.**

The above facts are accurate and true. I realize that failure to provide truthful information will cancel any approval of a bill reduction at Mt. Ascutney Hospital and Health Center. I give permission for Mt. Ascutney Hospital to verify any statement made above.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date