

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

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