Mt. Ascutney Hospital
289 County Road
Windsor, VT 05089

CONFIDENTIAL DISCLOSURE STATEMENT

1. Patient's name _____ Date of Birth_____
Phone #_____Patient's address_____
_____

2. Name of person responsible for payment of bill_____

3. Address if different from patients_____

4. Do you have health/medical insurance? Yes____ No____ Name of insurance_____
Certificate Number_____Effective Date of Policy_____

5. Have you applied for MEDICAID? Yes____ No____ If yes, Where? _____
When? _____MEDICAID Number_____Effective Date_____
If denied, please attach copy of Medicaid's denial letter. Reason why denied_____
_____

6. Do you own a home used for 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$_____

7. List all savings and checking accounts with banks or credit unions: Please circle one:
Bank/Credit Union_____ Checking/Savings/Other Amount $_____
Bank/Credit Union_____ Checking/Savings/Other Amount $_____

8. Do you have assets, such as property, investments, stocks and bonds? Yes____ No____
If yes, please give current value $_____ and provide current copy.

9. If you receive income from Social Security, disability, retirement, alimony, renters, pensions, food stamps, Unemployment compensation, or from friends/relatives, please list or attach list:
Type of income_____Monthly Amount $_____
Type of income_____MonthlyAmount$_____

10. If currently unemployed, last day of work_____When do you expect to return back to work_____

11. List all persons who are employed and contribute to the household income:

Name & Age	Employer	Last Year's Income	Weekly Gross

12. List other family members in household with outstanding bills_____
_____
_____

13. 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 $_____

14. Please provide information on the following monthly expenses:

Monthly Expense	Monthly Payment	Current Balance Due
Groceries	$_____	$_____
Electricity	$_____	$_____
Heating/gas/wood/propane	$_____	$_____
Homeowners/Auto Insurance	$_____	$_____
Phone	$_____	$_____
Child Care or Support	$_____	$_____
Life Insurance	$_____	$_____
Medications/Prescriptions	$_____	$_____
Other Medical Bills-co pays/deductibles	$_____	$_____

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

Name of Company	Monthly Payment	Balance Due
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

17. Please indicate the phone number and best time to contact you if additional information is needed
Phone_____ Time_____

18. What monthly payment would you be able to make toward your Hospital/Physician bill?
$_____

Please attach 3 current paycheck stubs and a complete copy of your last 3 Federal Income Tax Returns, Including W-2s. If you do not file a tax return, please list the reason why:
_____
_____.

If you have a direct deposit of your Social Security check, please send a copy of a bank statement showing the amount.

If you have a problem providing proof of your income, please contact us at (802) 674-7319. **WE ARE UNABLE TO PROCESS AN APPLICATION WITHOUT DOCUMENTATION. Please return form to: Mt. Ascutney Hospital, 289 County Rd. Windsor, VT 05089, ATTN: Jessica Farnsworth. Thank you. Applications take ONE month to process. If you send in your application and do not hear back from us in one month, please give us a call.**

I, THE UNDERSIGNED, CERTIFY that the above facts are accurate and true, and I realize that any falsification will cancel any approval of a bill reduction for services rendered at Mt. Ascutney Hospital and Health Center. I give permission for Mt. Ascutney Hospital to verify any statement made above.

_____ _____
Signature Date