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:

Monthly Expense	Monthly Payment	Unpaid Balance
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.)

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

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