Dartmouth Health

Mt. Ascutney Hospital and Health Center

FINANCIAL ASSISTANCE APPLICATION

(Any information you provide is *confidential* and is reviewed only by the staff processing your application)

1. PATIENT INFORMATION

Last Name | First Name | MI | Date of Birth

Email Address | Phone Number

Street Address | City | State | Zip Code

2. PERSON RESPONSIBLE FOR EXPENSES (*if different from above):*

Last Name | First Name | MI | Date of Birth

Email Address | Phone Number

Street Address | City | State | Zip Code

3. Please list **all** members of your household, including yourself:

	Name	Relationship to Patient	Date of Birth
1.			
2.			
3.			
4.			
5.			
6.			

4. Do you have health/medical insurance? Yes ☐ No ☐

Name of Insurance

Subscriber Name | Subscriber ID

Effective Date of Policy

5. Have you recently filed a worker' compensation or motor vehicle accident claim associated with unpaid bills at Mt. Ascutney Hospital and Health Center? Yes ☐ No ☐

6. Do you own a home used as your primary residence? Yes ☐ No ☐ Do you rent? Yes ☐ No ☐

7. Mortgage or Rent Amount $_____

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 $_____

INCOME INFORMATION

Please provide a copy of your Federal Tax Return and bank statement. In lieu of a tax return, you can submit paystubs, documentation of public assistance, a profit or loss statement, letter from employer, self-attestation in extenuating circumstances in which no other documentation is available, or other documentation that is considered valid documentation by the Vermont Department of Health Access. If you are claimed as a dependent on another person's taxes, the same documentation would apply for that person.

	Person 1	**Person 2**

8. **Name of household member**:_____

Monthly adjusted gross income from (*or specify yearly if using yearly amount*):

Employment	$	$
Self -Employment	$	$
Retirement (social security)	$	$
Unemployment	$	$
Other	$	$

Checking and Savings

Checking Account Balances	$	$
Savings	$	$

9. **MONTHLY EXPENSES:** Please provide information regarding your monthly expenses

	Monthly expenses:
Living (gas, food, clothes)	$_____
Utilities (phone, electric, etc.)	$_____
Insurance (Auto/Life/Property)	$_____
Health Insurance	$_____
Other	$_____
Healthcare Bills/Prescriptions	$_____

For questions or to make an appointment for in person assistance with your application, please contact our Customer Service Department at 802-674-7471 or email us at MAH.CS@mahhc.org

In-person assistance by appointment at the following locations:

- Mt. Ascutney Hospital and Health Center
  289 County Road, Windsor, VT 05089
- VT Ottauquechee Health Center
  32 Pleasant Street, Woodstock, VT 05091
- Mt Ascutney Hospital Ophthalmology
  80 S. Main Street Hanover, NH 03755

Please return application by mail to:	**or E-mail application to:**
Mt. Ascutney Hospital and Health Center Attn: Customer Service 289 County Road Windsor, VT 05089	Customer Service Department MAH.CS@mahhc.org
Additional copies of this application can be found at www.mtascutneyhospital.org	
If you do not hear from us in 30 Days, please contact us at 802-674-7471.	

_____ _____

Applicant Signature **Date**