

BRATTLEBORO MEMORIAL HOSPITAL
17 BELMONT AVENUE
BRATTLEBORO VT 05301
802 257 0341

ATTN: PATIENT FINANCIAL SERVICES
CFC REPRESENTATIVE
802 257 8240

APPLICATION FOR CHARITY FREE CARE PROGRAM

Patient Name: _____ Social Security No: _____

Address: _____ State: _____ Zip Code _____

Date Of Birth: _____ Phone (home): _____ (work) _____

PLEASE LIST ALL MEMBERS OF YOUR HOUSEHOLD AND COMPLETE ALL FIELDS

Name	Relationship to Patient	Date of Birth	Social Security No	Employer

INSURANCE

Insurance Name: _____ (Copy of Card)

Address of Insurance: _____

Subscriber: _____ Group# _____ Certificate # _____

WHAT IS YOUR MONTHLY HOUSEHOLD INCOME?

SOURCE OF INCOME

MONTHLY GROSS AMOUNTS

	Applicant	Co-Applicant	Other
Wages/Salary/Tips	_____	_____	_____
Social Security Benefits	_____	_____	_____
Workers Compensation	_____	_____	_____
Unemployment Benefits	_____	_____	_____
Child Support	_____	_____	_____
Pension	_____	_____	_____
Public Assistance (Welfare)/Food Stamps/Fuel Assistance	_____	_____	_____
Other Income	_____	_____	_____
Rental Income	_____	_____	_____
Interest Income	_____	_____	_____

TOTAL MONTHLY HOUSEHOLD INCOME \$ _____

(PROOF OF INCOME REQUIRED. PLEASE FURNISH OFFICE WITH FEDERAL TAX RETURN AND (3) RECENT PAYSTUBS FROM ALL WORKING MEMBERS OF THE HOUSEHOLD

(Remember to complete back of application)

WHAT IS YOUR MONTHLY HOUSEHOLD EXPENSES?

MONTHLY AMOUNT	BALANCE	MONTHLY AMOUNT	BALANCE
1st Mortgage _____		Property Taxes _____	
2nd Mortgage _____		Other Taxes _____	
Rent _____		Utilities _____	
Child Care _____		Food _____	
Auto Loan _____		Personal Loan _____	
Auto Insurance _____		Other Insurance _____	
Child Support _____		Credit Card _____	
Credit Card _____		Credit Card _____	
Doctors Owed _____		Other Facility Owed _____	
TOTAL MONTHLY HOUSEHOLD EXPENSES \$ _____			

If your household had no income or your expenses exceeded your income, please explain on a separate piece of paper how your obligations are being met and attach to this application.

HOUSEHOLD ASSETS

Property Owned _____	
Stocks & Bonds _____	Interest _____
CD (Certificate of Deposit) _____	IRA _____
Investment Income _____	Trust Accounts _____

Checking Account Balance \$ _____ Account # _____
 Name of Bank _____
 Address _____

Savings Account Balance \$ _____ Account # _____
 Name of Bank _____
 Address _____

I affirm that all information provided above is accurate to the best of my knowledge. I authorize Brattleboro Memorial Hospital to verify employment, income, expense and asset information as needed to determine eligibility. I understand that this program is the payor of last resort and therefore have made applications to any other insurance or federal and/or state assistance programs which may help with my medical bills for prior of future services.

SIGNATURE OF APPLICANT _____ DATE _____

SIGNATURE OF CO APPLICANT _____ DATE _____

For Office Staff Use Only.

A. Federal Poverty Income Guideline for _____ household = \$ _____

B. Household Monthly Income (\$ _____) X 12 = \$ _____

C. Line A minus Line B = \$ _____

(If Line B is greater than Line A, then household is over income for CFC program per current Federal Poverty Income Guidelines)

Outcome: CFC is approved. _____

CFC is denied. _____

CFC is pending for additional information: _____