



**Brattleboro Memorial Hospital**  
EXCEPTIONAL CARE FOR OUR COMMUNITY

**Brattleboro Memorial Hospital**  
**Financial Assistance Program**  
**17 Belmont Ave.**  
**Brattleboro, VT 05301**

## Brattleboro Memorial Hospital Financial Assistance Application

### Head of Household/Financial Guarantor Information

|                        |                   |                |              |     |
|------------------------|-------------------|----------------|--------------|-----|
| Head of Household Name |                   |                |              |     |
|                        |                   |                |              |     |
| Date of Birth          | Social Security # | Marital Status | Phone Number |     |
|                        |                   |                |              |     |
| Address                |                   | City           | State        | Zip |
|                        |                   |                |              |     |

### Household Members

List all family members who live in your household including a domestic partner. Domestic partner means a person who lives with you in a committed relationship. A partner does not include a roommate. If you need additional space, use the back of this form.

| Name | Date of Birth | Social Security # | Relationship |
|------|---------------|-------------------|--------------|
|      |               |                   |              |
|      |               |                   |              |
|      |               |                   |              |
|      |               |                   |              |
|      |               |                   |              |
|      |               |                   |              |

### Additional Information

|                                                                                                     |  |                              |                             |
|-----------------------------------------------------------------------------------------------------|--|------------------------------|-----------------------------|
| Are you covered under any health insurance policy? If yes, provide information below:               |  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Insurance Company Name                                                                              |  | ID#                          |                             |
| Have you applied for coverage for Vermont Medicaid?                                                 |  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you applied for coverage with the Vermont Health Exchange?                                     |  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you live in, work in, or go to school in Vermont?                                                |  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Would you like to talk with a Patient Advocate to see if you qualify for other forms of assistance? |  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

| Monthly Expenses           |  |                           |                                                      |
|----------------------------|--|---------------------------|------------------------------------------------------|
| Rent/Mortgage              |  | Medications               |                                                      |
| Property Tax               |  | Medications               |                                                      |
| Utilities (water/electric) |  | Healthcare Bills          |                                                      |
| Auto (car payment)         |  | Insurance (Auto/Property) |                                                      |
| Child Care                 |  | Alimony/Child Support     |                                                      |
| Living (food/gas)          |  | Other:                    | Please list below other expenses not mentioned above |
|                            |  |                           |                                                      |

| Employment                                                       |                                       |                         |
|------------------------------------------------------------------|---------------------------------------|-------------------------|
|                                                                  | Head of Household/Financial Guarantor | Spouse/Domestic Partner |
| Employer or circle if:<br>Retired /Student/ Unemployed/ Disabled |                                       |                         |

| Monthly Income                  |  |  |
|---------------------------------|--|--|
| Gross Salary/Wage               |  |  |
| Self-Employment income          |  |  |
| Social Security                 |  |  |
| Pension/Retirement Distribution |  |  |
| Disability (excludes VA)        |  |  |
| Unemployment                    |  |  |
| Rental Income                   |  |  |
| Divident Income                 |  |  |
| Other Income:                   |  |  |
|                                 |  |  |
|                                 |  |  |

| Liquid Assets<br>Cash/Savings/Investments |  |  |
|-------------------------------------------|--|--|
|-------------------------------------------|--|--|

|                           |                                       |                         |
|---------------------------|---------------------------------------|-------------------------|
|                           | Head of Household/Financial Guarantor | Spouse/Domestic Partner |
| Checking                  |                                       |                         |
| Savings                   |                                       |                         |
| CD                        |                                       |                         |
| Stocks/Mutual Funds       |                                       |                         |
| Bonds                     |                                       |                         |
| Annuities (if liquid)     |                                       |                         |
| Money Market              |                                       |                         |
| Trust Account (if liquid) |                                       |                         |
| Other:                    |                                       |                         |
|                           |                                       |                         |
|                           |                                       |                         |

| Additional Property (Does not include your primary residence) |       |                  |
|---------------------------------------------------------------|-------|------------------|
|                                                               | Value | Mortgage Balance |
| Vacation/Second Home                                          |       |                  |
| Land                                                          |       |                  |
| Rental Property                                               |       |                  |

Please include any other information about your current financial situation that you would like us to know. Such as difficulty paying for bills, rent, or food. If you need additional space, please write on the back.

Please mail with your completed application, along with supporting documentation to our Financial Assistance programs at the hospital. Qualification for assistance is based upon a series of criteria including an income and assets test. To process your application, please provide the applicable documentation listed below to support your financial need.

**Income:**

- ☐ Most recent federal income tax return
- ☐ In lieu of the federal income tax return, you may submit the alternatives listed below:
  - Employed/Self Employed:
    - ☐ Two of the most recent, consecutive earnings statements (pay stubs)
    - ☐ Written income verification from an employer (if paid in cash)
    - ☐ Written confirmation of migrant worker contract
  - ☐ Social Security: Current year benefit verification letter -or- most recent 1099-SSA statement
  - ☐ Pension/Retirement Distribution: Current benefit statement -or- most recent 1099-R statement
  - ☐ Unemployment: Current benefit statement
  - ☐ Rental Income: Year to date profit and loss statement if property is not included in assets
  - ☐ Documentation of public assistance (i.e. Medicaid, food stamps, etc)

**Liquid Assets:**

- ☐ Current statement from your financial institution(s) for:
  - ☐ Checking and savings (three months)
  - ☐ Certificate of Deposit
  - ☐ Stocks/Mutual Funds/Bonds/Money Market
  - ☐ Annuities, if liquid
  - ☐ Rental Property (if rental income is not included in your federal income tax return)

**Please Read Carefully**

I am requesting financial assistance from Brattleboro Memorial Hospital. I verify that all information I have provided is accurate and complete. Brattleboro Memorial Hospital has my permission to pursue verification of pertinent information. Any incorrect, incomplete or false information provided may cancel my application for financial assistance. I agree to repay the full financial assistance award if I receive payment of any kind for the medical services covered by this financial assistance application. All information will remain confidential under the provisions of HIPAA federal regulations.

I am attesting that I am a Vermont resident and qualify for financial assistance. If I am a non resident, then I understand that this application will only apply for outstanding balance(s) of Emergent Care.

|                                                    |              |
|----------------------------------------------------|--------------|
| Signature of Head of Household/Financial Guarantor | Date         |
| <br><br><br>                                       | <br><br><br> |

Please mail your completed application to the address below or drop it off at Brattleboro Memorial Hospital. Please ensure you enclose/attach the required documentation with the application

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