Brattleboro Memorial Hospital
EXCEPTIONAL CARE FOR OUR COMMUNITY

You may eligible for financial assistance from Brattleboro Memorial Hospital and the BMH Physician Group.
*To qualify you must have tried to get, and been refused, all other sources of payment including insurance, public assistance, or a lawsuit.

To find out if you or your household qualify:

(1) Complete a Financial Assistance application (enclosed)

(2) Provide proof of income with a COPY of each of the following that apply to your household:

- ☐ Most recent Federal Income Tax Return and all schedules. All pages required.
  - If you are not required to file, you must obtain "proof of non-filing" from the IRS. To request IRS form 4506-T call 802-257-8814.
  - If you are over age 65, not filing Federal taxes, AND only have Social Security as income: your Social Security Benefits Statement is sufficient.
- ☐ Last Year's W-2 Forms
- ☐ Paycheck Stubs - the three (3) most recent, consecutive stubs or a statement from your employer
- ☐ Bank Statements - the three (3) most recent, complete bank statements (e.g., savings, checking, money market, IRA, 401K, etc.) All pages and check copies for each account are required.
- ☐ Unemployment or Disability Compensation Benefits Statements
- ☐ Pension Benefits Stubs
- ☐ Social Security Income (yearly benefits statements, copy of check or direct deposit)
- ☐ Food Stamp Allocation
- ☐ Government Assistance Notices (including Department of Health & Human Services)
- ☐ Housing Subsidy Allotment
- ☐ Business Tax Return

Send to:

Financial Aid
17 Belmont Ave.
Brattleboro, VT 05301

Please note: if your financial information is not received in whole, it will result in an incomplete application.
For assistance or to schedule an in-person meeting, please call our Community Resource Liaison (802) 257-8814.

Brattleboro Memorial Hospital
APPLICATION FOR FINANCIAL ASSISTANCE PROGRAM

1. PATIENT INFORMATION (parent if the patient is a minor)

Last Name:_____ First Name: _____ Middle Name: _____

Date of Birth: _____ Social Security#: _____ Telephone#: _____

Cell Phone#: _____ Work#: _____

Mailing Address: _____ State: ____ Zip Code: _____

Spouse or Significant Other:

Last Name:_____ First Name: _____ Middle Name: _____

Date of Birth: _____ Social Security#: _____ Telephone#: _____

Cell Phone#: _____ Work#: _____

Mailing Address: _____ State: ____ Zip Code: _____

2. HEALTH INSURANCE INFORMATION

Do you have health insurance? ☐ Yes (please fill out this section) ☐ No (please skip to Section 3)

Health Insurer (please check all that apply):

Blue Cross ☐ CIGNA ☐ MVP ☐ Medicare ☐ Medicaid ☐ Other ☐ _____

Health Insurance ID#:_____ *(please attach a photo copy of your insurance card)*

3. EMPLOYMENT INFORMATION

Are you presently employed?

Yes ☐

Employer Name:_____

Employer Address: _____

Employer Phone#: _____

Length of employment: _____

No ☐

Date last worked: _____

4. MEMBERS OF HOUSEHOLD INFORMATION

Full Name	Relationship to Patient	Dependent? (Yes/No)	Date of Birth	Social Security#	Employer (if applicable)

Dependents are people who you have claimed on your Federal Income Tax Return as a dependent

5. HOUSEHOLD INCOME Please indicate your monthly household income below:

Description	Patient (Applicant)	Spouse	Other	Total
Wages/Salary/Tips				
Social Security Benefits				
Workers Compensation				
Unemployment Benefits				
Pension				
Public Assistance (welfare, food stamps, fuel assist)				
Child Support Income				
Alimony income				
Rental income				
interest income				
Other income (please specify below)				
_____				
_____				
_____				
			Total Monthly Household Income:	

6. HOUSEHOLD EXPENSES Please indicate your monthly household expenses below:

Description	Patient (Applicant)	Spouse	Other	Total
Rent				
Mortgage(s)				
Auto loans				
Insurance				
Child Support expense				
Alimony expense				
Child Care/Day Care expense				
Credit Card expense				
Medical expenses				
Property Taxes				
Utilities				
Food				
Other expenses (please specify below)				
_____				
_____				
_____				
			Total Monthly Household Expenses:	

If your household had no income or your expenses exceeded your income, please explain below how your obligations are being met:

7. HOUSEHOLD ASSETS

Description		Financial Institution	Account Number	Balance in Account
Checking Accounts	1			
	2			
	3			
Savings Accounts	1			
	2			
	3			
Property Owned	1			
	2			
	3			
Other Assets (please specify)	1			
	2			
	3			
			Total Account Balances:	

8. REQUIRED DOCUMENTATION

A. Does anyone in your household receive Social Security or Disability Benefits? ☐ Yes ☐ No
If Yes, please provide a current copies of benefit statements. To obtain copies, please call the Social Security office at 1-866-690-2025.

B. Does anyone in your household receive Unemployment Benefits or Pension/Annuity Benefits? ☐ Yes ☐ No
If Yes, please provide copies of current benefit statements.

C. Does anyone in your household receive any of the following assistance? ☐ Food Stamps ☐ Housing Subsidy ☐ ANFC ☐ SSI
If you selected any of the programs above, please provide copies of current benefit statements showing the amount received.

D. Is anyone in your household required to file a Federal Income Tax Return? ☐ Yes ☐ No
If yes, please provide a copy of your most recent Federal Income Tax Return(s), including all schedules, for each member of your household and 30 days' worth of pay stubs from all employers. To obtain a copy of your tax return(s), please call 1-800-829-1040.

E. Is anyone in your household self employed? ☐ Yes ☐ No
If yes, please provide copies of the most recent Business Tax Return and the least 3 months. of ledgers showing income and expenses.

F. Please provide 3 consecutive months of Bank Statements for all accounts shown in the Household Assets section above.

G. Please provide a written statement of any other special circumstances and attach it to this application.

9. CERTIFICATION

I affirm that all information provided above is accurate to the best of my knowledge. I authorize Brattleboro Memorial Hospital to verify employment, income, expenses 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 or future services.

SIGNATURE OF PATIENT: _____ DATE: _____

SIGNATURE OF SPOUSE: _____ DATE: _____

If you do not have some or any of the listed documents to prove household income, you may call the BMH Community Resource Liaison and discuss other evidence that may be provided to demonstrate eligibility.