Financial Assistance Application

Return to: NCH, 189 Prouty Drive, Newport VT 05855
802-334-3273/802-334-3274

North Country Hospital
Where caring runs deep.

1. Patient's Information:

All personal information will be held in strictest confidence.

First Name | Last Name | Middle Initial | Date of Birth | Date

Street Address | City | State | Zip | Length at this Address

Mailing Address | City | State | Zip

Home Phone Number | Work Phone Number | Cell Phone Number

2.Person Responsible for Paying the Bill

First Name | Last Name | Middle Initial | Phone Number Home | Work | Cell

3. ***Please list ALL people living in the household, including applicant: Use additional paper if needed

	Name	Relationship to Patient	Age	Date of Birth	Social Security #	Current Health Coverage
1.		SELF				
2.						
3.						
4.						
5.						
6.						

4. Have you applied for financial assistance at another facility? ☐ Yes ☐ No Where? _____

5. Is anyone in your household pregnant? ☐ Yes ☐ No Whom? _____

6. Is anyone in your household currently uninsured? ☐ Yes ☐ No Mark No under Current Health Care Above

7. If you are uninsured did you apply for insurance through the Health Care Exchange? ☐ Yes ☐ No
If not why? _____

8. Have you filed a workers's compensation or motor vehicle accident claim? ☐ Yes ☐ No
If yes date of accident or injury? _____ Name of Insurance Carrier? _____Policy #_____

9. Is anyone in your household eligible for Social Security Benefits? ☐ Yes ☐ No Who: _____

10. Has anyone applied for Medicaid? ☐ Yes ☐ No Fuel Assistance? ☐ Yes ☐ No Food? ☐ Yes ☐ No

11. Have you been denied health care? Explain _____

12. Household Income Information

	Person 1	Person 2	Person 3
NAME of Household Member			
MONTHLY INCOME			
Employment	$	$	$
Self Employment	$	$	$
Investment Account	$	$	$
Real Estate (i.e. Rentals)	$	$	$
Unemployment(Since __/__/__)	$	$	$
Retirement(Social Security)	$	$	$
Pension/Annuities	$	$	$
Alimony/Child Support	$	$	$
Public Assistance, Fuel, Food	$	$	$
Other Income Specify: _____	$	$	$
SAVINGS/INVESTMENTS			
Checking Account	$	$	$
Savings Account/CD's	$	$	$
IRA, 403B, 401 K Specify: (_____)	$	$	$
Mutual Funds/Stocks/Bonds	$	$	$
Other Savings/Investments Specify: (_____)	$	$	$
LIST OF VEHICLES	Make	Model	Year
Car			
Car			
Truck			
Camper			
Recreational Vehicles			

13. Household Expenses- Monthly (if Yearly Specify –Yr)

Monthly Rent Payment: $_____ Monthly Mortgage Payment: $_____
Value Primary Residence: $_____ Property Tax Listing $_____ Mortgage Balance: $_____
Other Property: Value $_____ Property Tax Listing $_____ Mortgage Balance: $_____
Type of Property Owned and Value if additional properties:
Mobile Home: $_____ Farm: $_____Camp: $_____ Acreage: $_____ Business: $_____

Utilities	$	Insurance(Auto/Life)	$	Property Insurance	$
Heat	$	Gas/Food	$	Health Care Bills	$
Child Care	$	Alimony/Child Support	$	Medications	$
Cable/TV/Intranet	$	Credit Card:	$	Other:	%

14. Liabilities/Loans/Mortgage (Mortgage, School, Credit Card Debt, Vehicles, other)

Name of Creditor	What Purchased	Amount Financed	Unpaid Balance	Monthly Payment
		$	$	$
		S	$	$
		$	$	$
		$	$	$
		$	$	$
			Total: $	Total: $

I certify that the information in this application is true and correct to the best of my knowledge. I will apply for any state, federal, or local assistance for which I may be eligible to help pay for this hospital bill. I understand that the information provided may be verified by the hospital, and I authorize the hospital to contact third parties to verify the accuracy of the information provided in this application. I understand that if I knowingly provide untrue information in this application, I will be ineligible for financial assistance, any financial assistance granted to me may be reversed, and I will be responsible for the full payment of the hospital bill.

Signature of Applicant: _____ Date: _____
Signature of Applicant: _____ Date: _____
Signature of Applicant: _____ Date: _____