

**Responsible Party Information (Please Print)**

Name \_\_\_\_\_  
First/ Middle/ Last

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_

Current Residence \_\_\_\_\_  
Street City State

Current Mailing \_\_\_\_\_  
Street / Po Box

\_\_\_\_\_ City State Zip Code

**Health Insurance**

BCBS- ID# \_\_\_\_\_

Medicare- ID# \_\_\_\_\_

Cigna- ID# \_\_\_\_\_

MVP- ID# \_\_\_\_\_

Medicaid-ID# \_\_\_\_\_

Other: \_\_\_\_\_ ID# \_\_\_\_\_

**Presently Employed?**  
Yes or No

Employer's Name: \_\_\_\_\_ Date last Worked? \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Length of Employment: \_\_\_\_\_

**Spouse/Partner Employed?**  
Yes or No

Employer's Name: \_\_\_\_\_ Date last Worked? \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Length of Employment: \_\_\_\_\_

**Have you applied for Green Mountain Cares Program? Yes or No**  
(Medicaid / VHAP/ Dr. Dinosaur) If denied, please explain why below.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**HOUSEHOLD INFORMATION:**  
How many people are residing in your home, including yourself? \_\_\_\_\_

Please list everyone residing in your home and their relationship to you:

Full Name	Date of Birth	Relation to You	Monthly Income
1.			
2.			
3.			
4.			
5.			
6.			
7.			

**Monthly Income**

Gross Household Wages (before taxes)	\$
Self-Employment after deductions from Schedule C (excluding depreciation)	\$
Interest Income	\$
Child Support / Alimony Received	\$
Rental Property Income	\$
Pension / Retirement / Unemployment / Workmen's Comp	\$
Other:	\$
<b>Total Monthly Income (before taxes)</b>	\$
<b>Total Yearly Income (before taxes)</b>	\$

If you need more space, list additional people on a separate piece of paper and attach to this application.



ASSETS					<b>Required Documentation</b>																																										
Please list your household's financial assets.					<b>Applications received without supporting documents cannot be processed and will be returned to you.</b>																																										
<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 10%;"></th> <th style="width: 20%;">Financial Institution</th> <th style="width: 20%;">Account Number</th> <th style="width: 20%;">Balance in Account</th> <th style="width: 30%;">Documentation Required</th> </tr> </thead> <tbody> <tr> <td rowspan="3" style="vertical-align: top;">Checking Accounts</td> <td>1.</td> <td></td> <td></td> <td rowspan="3" style="vertical-align: top;"><b>Please Provide:</b> 3 consecutive months of bank or other financial statements.</td> </tr> <tr> <td>2.</td> <td></td> <td></td> </tr> <tr> <td>3.</td> <td></td> <td></td> </tr> <tr> <td rowspan="3" style="vertical-align: top;">Savings Accounts</td> <td>1.</td> <td></td> <td></td> <td rowspan="3" style="vertical-align: top;"><b>Please Provide:</b> 3 consecutive months of bank or other financial statements.</td> </tr> <tr> <td>2.</td> <td></td> <td></td> </tr> <tr> <td>3.</td> <td></td> <td></td> </tr> <tr> <td rowspan="3" style="vertical-align: top;">Real Estate Value</td> <td>1.</td> <td></td> <td></td> <td rowspan="3" style="vertical-align: top;"><b>Please Provide:</b> Documentation (tax bill, mortgage agreement, tax return) that clearly identifies Real Estate Value for all properties owned.</td> </tr> <tr> <td>2.</td> <td></td> <td></td> </tr> <tr> <td>3.</td> <td></td> <td></td> </tr> </tbody> </table>						Financial Institution	Account Number	Balance in Account	Documentation Required	Checking Accounts	1.			<b>Please Provide:</b> 3 consecutive months of bank or other financial statements.	2.			3.			Savings Accounts	1.			<b>Please Provide:</b> 3 consecutive months of bank or other financial statements.	2.			3.			Real Estate Value	1.			<b>Please Provide:</b> Documentation (tax bill, mortgage agreement, tax return) that clearly identifies Real Estate Value for all properties owned.	2.			3.			<b>1. Does anyone in your household receive Social Security Benefits or Disability Benefits? Yes or No</b> If yes, please include current copies of current benefit statement. To obtain a copy of this, please call the Social Security Office at 1-866-690-2025.				
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Total Account Balances: <b>If you have more than 3 checking or savings accounts please, include an additional sheet of paper listing them.</b>					<b>2. Does anyone in your household receive Unemployment Benefits or Pension/Annuity Benefits? Yes or No</b> If Yes, please provide copies of current benefit statements.																																										
					<b>3. Is anyone in your household required to file Federal Income Taxes? Yes or No</b> 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 90 days' worth of pay stubs from all employers. To obtain a copy of your tax return(s), please call 1-800-829-1040.																																										
I certify that the information provided above is an accurate and true representation of my financial information. I also certify that there is no additional insurance coverage for this patient. I understand that providing false information will result in denial of the application for any type of financial assistance through Grace Cottage Hospital and/or Grace Cottage Family Health (GCH/GCFH). If I am entitled to any action against or settlement from third party payers, I will take any action necessary or requested by GCH/GCFH to obtain such assistance and will assign to GCH/GCFH, and upon receipt, will pay GCH/GCFH, all amounts recovered up to the total amount of the outstanding balance on my bill. My failure to apply for such assistance or follow through with the application process or take those actions reasonably necessary or requested by GCH/GCFH will result in the denial and/or revocation of this application.  If you have any questions, please feel free to contact Verna Joslyn of the Finance Department at GC 802-365-3647 or <a href="mailto:voslyn@gracecottage.org">voslyn@gracecottage.org</a> .					<b>4. Is anyone in your household self-employed? Yes or No</b> If yes, please provide copies of the most recent Business Tax Return including Schedule C.																																										
					<b>**If you are unemployed and there is no income coming into the household, a written letter explaining how you are supporting yourself is required.**</b>																																										
For Office Use Only:  APPROVED <input type="checkbox"/> % Discount or DENIED: Income <input type="checkbox"/> SA <input type="checkbox"/> Other <input type="checkbox"/>  Account Balance after RFA: <input type="text"/> Minimum Monthly Payment: <input type="text"/>  Patient / Guarantor will pay: Balance in Full <input type="checkbox"/> or Monthly Payment <input type="text"/>  Approved By <input type="text"/>  Approved Date <input type="text"/>					Please provide a written statement of any other extenuating circumstances that you would like us to know about. If applying for Reduced Fee/Free Care on balances aged more than 30 days this written statement will be required for consideration.																																										
					Patient Called <input type="checkbox"/> Letter Sent to Patient <input type="checkbox"/> Account Adjusted <input type="checkbox"/>																																										

Signature of Applicant: \_\_\_\_\_

Date: \_\_\_\_\_