Po Box 216
Townshend, VT 05353

Grace Cottage
Financial Assistance Application

Responsible Party Information (Please Print)

Name: _____
First/ Middle/ Last

Date of Birth: ____/____/____ **Telephone:** (____)_____ **Mobile:**(____)_____

Current Residence Address: _____
Street City State Zip Code

Current Mailing Address: ___ _____
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. Dynasaur) If denied, please explain why below.

_____
_____
_____
_____
_____
_____

HOUSEHOLD INFORMATION:
How many people are residing in your home, including yourself? _____
Are you a tax dependent (does someone else claim you as a dependent on their taxes) _____

Please list spouse/domestic partner and all tax dependents (if you don't file taxes please list those who would qualify as a tax dependent:

Full Name	Date of Birth	Relation to You	Is Individual a Tax Dependent: Yes or No	Monthly Income
1.				
2.				
3.				
4.				
5.				
6.				
7.				

Required Documentation

Please provide a copy of your most recent tax filing. If you cannot provide a tax return, please provide alternative documentation such as paystubs, SS Benefit statement, pension benefit statement, bank statement, profit & loss statement, documentation of public assistance, letter from an employer or a self-attestation letter. A self-attestation letter is only for extenuating circumstances in which no other documentation is available and will be discussed upon receipt of application. If you are unemployed and there is no income coming into the household a written letter explaining is required.

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HOUSEHOLD INCOME

Gross Household Wages (before taxes)	$
Self-Employment after deductions from Schedule C (excluding depreciation)	$
Interest Income	$
Rental Property Income	$
Pension / Retirement / Unemployment	$
Other:	$
Total Gross Monthly Income (before taxes)	$
Total Gross Yearly Income (before taxes)	$

Office Use Only:

APPROVED ☐ % Discount or DENIED: Income ☐ SA ☐ Other ☐

Account Balance after RFA: ☐
Minimum Monthly Payment: ☐

Patient Called ☐
Letter Sent to Patient ☐
Account Adjusted ☐

Patient / Guarantor will pay:
Balance in Full ☐ or Monthly Payment ☐

Approved By ☐

Approved Date ☐

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