

**SPRINGFIELD HOSPITAL
PO BOX 2003
SPRINGFIELD, VT 05156**

REQUEST FOR DETERMINATION OF ELIGIBILITY FOR FINANCIAL ASSISTANCE

In order to qualify for consideration for financial assistance, please:

- 1) Complete this form and SIGN (indicated below) Please read carefully.
- 2) Attach verification of your income and provide us with all documents requested that will help us determine your needs.

PLEASE ATTACH:

A copy of your 2006 IRS income tax return. If you have not filed a 2006 income tax return, please state briefly why.

Copies of two current paycheck stubs and/or copies of two stubs from previous employers.

If you receive Social Security, either a Social Security Statement of Benefits, a copy of the check, or, if you have direct deposit, a copy of the bank statement showing the amount.

A copy of your Medicaid denial, if you applied yourself, or we requested you applies.

Your application may be delayed or rejected if information or documentation is missing. WE DO NOT GRANT FINANCIAL ASSISTANCE ON ANY SURGERIES THAT ARE NOT MEDICALLY NECESSARY.

Please indicate a daytime telephone number where we can contact you if additional information is needed. _____

If you have any questions regarding completion of this form, please contact:
Financial Services Department, (802) 885-7631 or 7630. Please call us if your application will be delayed.

Please return the required documentation and forms by _____.
To: Financial Services Department, Springfield Hospital, PO Box 2003, Springfield, VT 05156.

You will receive written notification of our decision as soon as possible. I hereby request that Springfield Hospital make a determination of my eligibility for financial assistance at Springfield Hospital. I understand that if the information, which I submit is determined to be false, such a determination will result in a denial for financial assistance, and that I will be liable for charges for services rendered.

I CERTIFY THAT THE INFORMATION I HAVE GIVEN IS CORRECT, TRUE AND COMPLETE. I ALSO GIVE SPRINGFIELD HOSPITAL PERMISSION TO INVESTIGATE ALL FACTS RELATING TO MY ELIGIBILITY.

DATE

SIGNATURE GUARANTOR/PERSON FINANCIALLY RESPONSIBLE

PATIENT NAME(s)

_____ DATE OF BIRTH _____

_____ SOCIAL SECURITY# _____

PATIENT

ADDRESS _____ TEL# _____

PERSON FINANCIALLY RESPONSIBLE:

ADDRESS: _____

OCCUPATION: _____ TEL# _____

HOSPITAL INSURANCE CARRIER _____

NUMBER OF CHILDREN UNDER 18 YEARS OF AGE LIVING AT HOME _____

LIST ALL NAMES WITHIN YOUR HOUSEHOLD AND ALL DEPENDENTS.

NAME	RELATIONSHIP	AGE
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PLEASE LIST ALL PERSON (S) EMPLOYED OR WHO RECEIVE AN INCOME WITHIN YOUR HOUSEHOLD:

NAME	EMPLOYER/INCOME SOURCE	GROSS MONTHLY INCOME
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

INCOME: (LIST TOTAL INCOME FOR THE FAMILY FROM THE FOLLOWING)

TOTAL FOR LAST MONTH

GROSS WAGES	\$ _____
FARM INCOME OR SELF EMPLOYMENT	\$ _____
PUBLIC ASSISTANCE/VETERANS SERVICES	\$ _____
SOCIAL SECURITY/S.S.I	\$ _____
UNEMPLOYMENT COMPENSATION	\$ _____
ALIMONY	\$ _____
CHILD SUPPORT	\$ _____
PENSIONS (VA, PRIVATE, EMPLOYEE	\$ _____
INCOME FROM DIVIDENS, INTEREST, RENT	\$ _____
AN OTHER INCOME	\$ _____
 TOTAL INCOME	 \$ _____

IF YOU ARE CLAIMING 0 INCOME FOR THE LAST 3 MONTHS, PLEASE WRITE ON THE LAST PAGE HOW YOU ARE MEETING YOUR MONTHLY EXPENSES.

CASH ASSETS: BANK OR CREDIT UNION ACCOUNTS

BANK/CREDIT UNION _____	AMOUNT\$ _____
BANK/CREDIT UNION _____	AMOUNT\$ _____

PLEASE LIST BELOW ANY HOUSEHOLD & MEDICAL BILLS OWED ALONG WITH THE COST OF MONTHLY PRESCRIPTIONS THAT YOU PAY FOR.

Note: This information will be retained as confidential and will be used within Springfield Hospital for the purpose of determining financial assistance eligibility.

