



Dear Patient:

Thank you for choosing Northwestern Medical Center for your health care needs. If payment of your medical bills would create a financial hardship for you, we will work with you to apply for financial assistance. All other potential payment sources will be required first such as insurance payments, etc. We may require that you apply for Medicaid.

**Please answer all questions on the application completely—indicate “zero” or “does not apply” where appropriate. Applications that are incomplete or do not have appropriate proof of income will be returned requesting additional information. We will continue to bill you during this process.**

The following proof of income is requested:

- A signed copy of 2008 tax return.
- Copies of Social Security checks or documentation from Social Security of your benefits
- A bank statement showing direct deposits of retirement or Social Security benefits.
- Proof of Child Support paid or received

We will notify you of our decision within 30 days of receipt of a complete application. If you have any further questions regarding this process, please contact me at (802) 524-1065.

Sincerely,

Lisa Cornforth  
Senior Collection Representative

NORTHWESTERN MEDICAL CENTER  
REQUEST FOR FINANCIAL ASSISTANCE

***PATIENT INFORMATION***

Name \_\_\_\_\_  
Mailing Address \_\_\_\_\_  
Daytime Phone \_\_\_\_\_

***GUARANTOR/SPOUSE***

Name \_\_\_\_\_  
Mailing Address (if different than above) \_\_\_\_\_  
Daytime Phone \_\_\_\_\_  
Employer \_\_\_\_\_  
Social Security Number \_\_\_\_\_

***NAME AND AGES OF PEOPLE PATIENT/GUARANTOR/SPOUSE ARE FINANCIALLY RESPONSIBLE FOR:***

Name	_____	Age	_____
Name	_____	Age	_____
Name	_____	Age	_____
Name	_____	Age	_____

PLEASE COMPLETE THE ATTACHED FINANCIAL DISCLOSURE WORKSHEETS AND  
ENCLOSE THE SUPPORTING DOCUMENTATION DESCRIBED IN THE ATTACHED LETTER

I affirm that all information provided on this application is accurate to the best of my knowledge. I authorize Northwestern Medical Center to verify employment, and all financial information provided herein to determine eligibility for financial assistance.

Signature of Patient or Guarantor \_\_\_\_\_  
Print Name of Person Completing this Application \_\_\_\_\_  
Date \_\_\_\_\_

MONTHLY HOUSEHOLD NET INCOME

Income

Gross salaries/wages/tips	\$ _____
Social security payments received	_____
Pension or retirement payments received	_____
Interest income	_____
Dividend income	_____
Unemployment/workers' compensation payments received	_____
Rental income	_____
Child support/alimony payments received	_____
Other (describe):	_____
_____	_____
_____	_____
Total Monthly Income	\$ _____

Expenses

Mortgage/rent	\$ _____
Property taxes	_____
Auto loans	_____
Credit card payments	_____
Utilities	_____
Child support/alimony	_____
Insurance--auto, home, health	_____
Medical expenses	_____
Other living expenses--telephone, heat,food,gas,water,sewer,rubbish,water	_____
Other (describe):	_____
_____	_____
_____	_____
Total Monthly Expenses	\$ _____

TOTAL MONTHLY HOUSEHOLD NET INCOME  
(monthly income minus monthly expenses) \$ \_\_\_\_\_

PATIENT NAME \_\_\_\_\_

NET WORTH

Assets

Balance in checking accounts \$ \_\_\_\_\_

Balance in savings accounts \_\_\_\_\_

CDs \_\_\_\_\_

Stocks \_\_\_\_\_

IRAs, 401ks, and other retirement funds \_\_\_\_\_

Market value of real estate (other than primary residence) \_\_\_\_\_

Market value of autos \_\_\_\_\_

Other assets (describe):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Total Assets \$ \_\_\_\_\_

Liabilities

Outstanding balance on credit cards \$ \_\_\_\_\_

Outstanding balance on auto loans \_\_\_\_\_

Outstanding balance on real estate loans (excluding primary residence) \_\_\_\_\_

Other debt (describe):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Total Liabilities \$ \_\_\_\_\_

NET WORTH (total assets minus total liabilities) \$ \_\_\_\_\_