Dear Patient:

Thank you for choosing Northwestern Medical Center for your health care needs. If payment of your medical bills creates a financial hardship for you, we will work with you to apply for financial assistance. All other potential payment sources will need to be explored first, such as insurance, Government programs, etc.

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.

Please list your spouse or domestic partner and all tax dependents. If you don't file taxes, please list the people who would be your tax dependents if you filed.

We need proof of your income. Please give us a copy of your most recent federal tax return. If you do not file taxes or it does not reflect your current income, you can give us another document as proof. For example: A recent paystub showing your year-to-date totals, a W2, unemployment statements, notices of security retirement benefits, a profit and loss statement, etc.

We will notify you of our decision within 15 days of receipt of a complete application. If you have any questions regarding this process, please contact us at (802)524-1048.

***All personal information submitted will be held in strictest confidence.**

Sincerely,

Customer Service (802)524-1048

NORTHWESTERN MEDICAL CENTER
REQUEST FOR FINANCIAL ASSISTANCE

Patient Information

Name _____

Mailing Address _____

_____

Daytime Phone _____

Spouse / Domestic Partner

Name _____

Mailing Address *(if different than above)* _____

_____

Daytime Phone _____

Employer _____

Social Security Number _____

Tax Dependents

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

* If you don't file taxes, please list the people who would be your tax dependents if you filed

PLEASE COMPLETE THE FINANCIAL DISCLOSURE WORKSHEETS AND ENCLOSE THE SUPPORTING DOCUMETATION DESCRIBED ABOVE

Signature of Patient / Guarantor _____
Print Name of Person Completing this Application _____
Date _____

NORTHWESTERN MEDICAL CENTER
REQUEST FOR FINANCIAL ASSISTANCE

Monthly Household Income

Gross Salary Salaries / Wages / Tips $_____
Business Income / Farm Income $_____
Capital Gain / other gains (or loss) $_____
Taxable Social Security Payments Received $_____
Taxable Pension / Taxable Retirement Payments Received $_____
Taxable Interest Income $_____
Ordinary Dividends $_____
Unemployment Income $_____
Rental Income $_____
Alimony $_____
(received under settlements executed before 2019) Settlement Date:_____
Rental Real Estate Income $_____
Other Income (please describe): $_____
_____

Total Monthly Gross Income **$_____**

Expenses

Mortgage / Rent $_____
Property Taxes $_____
Auto Loans $_____
Credit Card Payments $_____
Utilities $_____
Child Support / Alimony $_____
Insurance (Auto, Home, Health, etc.) $_____
Medical Expenses $_____
Other Living Expenses
(Telephone, Heat, Food, Gas, Water, Rubbish, etc.) $_____

Other (please describe): $_____
_____

Total Monthly Expenses **$_____**

Total Monthly Gross Household Income **$_____**
(monthly income minus monthly expenses)

NORTHWESTERN MEDICAL CENTER
REQUEST FOR FINANCIAL ASSISTANCE

Liquid Assets

Balance in Checking Accounts $_____
Balance in Savings Accounts $_____
CDs $_____
Stocks $_____
Market Value of Real Estate (other than primary residence) $_____
Market Value of Recreational Autos $_____
Other Liquid Assets (please 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 (please describe): $_____

_____

_____

Total Liabilities **$_____**

Net Worth (total assets minus total liability) **$_____**