NORTHERN TIER CENTER FOR HEALTH

NOTCH

Financial Assistance Program Application

Northern Tier Center for Health
44 Main Street, Suite 200
Richford, VT 05476

Billing Department
Phone (802) 255-5580
Fax (802) 255-5589

Applicant

Name: Last _____First _____MI ____

Date of Birth _____SS# If avail_____

Single☐ Married☐ Divorced☐ Separated☐ Widowed☐

Mailing Address_____

City_____ ZIP_____ Phone_____

Physical 911 Address (cannot be PO Box)

Street Address_____

City_____ ZIP_____

Co-Applicant

Name: Last _____First _____MI ____

Date of Birth _____ SS# If avail _____

Children/Dependents

Name	Relationship	Birth Date	SS # If Avail
1.			
2.			
3.			
4			
5.			

Please Provide a full copy of your most recent Income Tax Return. If you do not file an Income Tax Return we will accept one of the following:
Social Security Benefit Statement, **3 current paystubs,** or **employers verification of income** (hours worked and wage per hour) **on company letterhead**, or a **Self Declaration of Income**.

By Signing below I authorize NOTCH to release the financial information I've provided with this application to **Northwestern Medical Center, Inc. (NMC)** to apply for additional Financial Assistance being offered by NMC for NMC services. **Approval or denial of NMC Financial Assistance Program is not contingent upon NOTCH Financial Assistance approval.**

To the best of my knowledge, the information provided with this application is true and correct. I agree to inform NOTCH of any changes in my employment or financial status. If the information proves to be incorrect, I understand that the discount provided to me will be terminated. I also give permission for NOTCH to contact my employer or any other source to verify income when necessary.

Signature of Applicant _____ Date _____

Do you or any members of your household have Health Insurance? ◯ YES ◯ NO

If you are a woman age 21-64 you may be eligible for You First. It is a free health benefit that covers breast, cervical, and heart health screenings.

I am interested in You First for myself, or family member. ◯ **YES** ◯ **NO**

FOR CENTER USE ONLY: *Gross Monthly income* _____ *Gross Annual income* _____

*Authorized Initials*_____*Sliding Fee Medical/Dental* _____ *Approval/Denial Date*_____*to* _____

Northwestern Medical Center (NMC) Sliding Fee Program use ONLY

NET WORTH

Applicant Name: _____

Assets	
Balance in checking accounts	
Balance in savings accounts	
Certificate of Deposits (CD's)	
Stocks	
IRAs, 401ks, & other Retirement funds	
Market value of Real Estate (other than primary residence)	
Market value of Autos	
Other Assets (describe): _____	
Total Assets	$ 0

Liabilities	
Outstanding balance on credit cards	
Outstanding balance on auto loans	
Outstanding balance on Real Estate loans (other than primary residence)	
Other Debt (describe): _____	
Total Liabilities	$ 0
NET WORTH (total assets minus total liabilities)	**$**

MONTHLY INCOME & EXPENSES

Income ***(MUST provide documentation to support ALL Income)***	
Gross Salaries/Wages (before taxes & deductions)	
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	$ 0

Expenses	
Mortgage/Rent	
Property Taxes	
Auto Loans	
Credit Card Payments	
Utilities	
Child Support/Alimony Payments	
Insurance, auto, home, health	
Medical expenses	
Other Living Expenses- telephone, heat, food, gas, water, rubbish, sewer	
Other (describe): _____	
_____	
Total Monthly Expenses	$ 0
TOTAL MONTHLY HOUSEHOLD NET INCOME (Income less Expenses)	**$** 0

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Self Declaration of Income

Please select one of the following options:

OPTION A:
I, _____, declare that I have been working and receiving payment in cash in the amount of $ _____ per (**circle one**) day, week, two-weeks, or month. I have no check stubs or other documentation to prove my earnings.

OPTION B:
I, _____, declare that I have no employment and do not have income of any kind.

1. How do you pay for food _____
2. How do you pay for heat and rent_____
3. Do you receive Food Stamps _____
4. Do you receive child support/alimony _____
5. Do you receive social security_____
6. Did you file income tax last year – (IF YES PLEASE PROVIDE A COPY – IF CURRENTLY NOT WORKING PLEASE PROVIDE EXPLANATION)

_____

_____

Signature: _____

Date: _____