Financial Assistance Application
PROOF OF INCOME is required as explained below.

Primary Applicant *(Parent if patient is a minor)*				
Last Name	*First*	*Middle*	*Date of Birth*	*Phone*
Mailing Address			*Enrolled in:* *Medicaid?* ☐ Yes ☐ No *Medicare?* ☐ Yes ☐ No	

Spouse or Significant Other Information				
Last Name	*First*	*Middle*	*Date of Birth*	*Phone*
Mailing Address			*Enrolled in:* *Medicaid?* ☐ Yes ☐ No *Medicare?* ☐ Yes ☐ No	

Dependent's Information *(Please note: only dependents claimed on your Federal tax return may be included here—attach a piece of paper for additional dependents if needed)*				
Last Name	*First*	*Middle*	*Date of Birth*	*Medicaid?* ☐ Yes ☐ No *Medicare?* ☐ Yes ☐ No
Last Name	*First*	*Middle*	*Date of Birth*	*Medicaid?* ☐ Yes ☐ No *Medicare?* ☐ Yes ☐ No
Last Name	*First*	*Middle*	*Date of Birth*	*Medicaid?* ☐ Yes ☐ No *Medicare?* ☐ Yes ☐ No
Last Name	*First*	*Middle*	*Date of Birth*	*Medicaid?* ☐ Yes ☐ No *Medicare?* ☐ Yes ☐ No

THIS APPLICATION APPLIES TO ALL OF OUR PRACTICES (*some services may not apply*)

Lamoille Health Family Medicine, Morrisville & Stowe | Lamoille Health Family Dentistry
Lamoille Health Behavioral Health & Wellness | Lamoille Health Pediatrics

Estimated Monthly <u>Household</u> Income *(Proof of income must be provided, which may include: a copy of a recent pay stub, Social Security determination letter, or tax return if self-employed)*		
Gross Wages (before tax) *$*	*Worker's Compensation* *$*	*Alimony Received* *$*
Pensions *$*	*Unemployment* *$*	*Other income* *$*
Social Security *$*	*State/Federal Assistance* *$*	*(Please specify)*

Use of Personal Financial Information Disclosure, Authorization and Release for Application for Assistance
I hereby authorize Lamoille Health Partners to utilize the financial information I am providing, to process my application for financial assistance as a patient at Lamoille Health Partners. I certify all of the information provided on or with this application is true and accurate.

☐ PROOF OF INCOME ENCLOSED?

(Proof of income must be provided within 7 business days to be eligible for any discount you may receive today)

Signature of Primary Applicant _____ *Date* _____

Return this completed application, along with your proof of income, to your Physician's Office or mail to:
Lamoille Health Partners, P.O. Box 749, Morrisville, VT 05661