Berkshire Medical Center
Endoscopy Patient Fund Application

I, _____, verify that I have provided the following information accurately to _____, in order to determine my eligibility for enrollment into the patient fund to help cover out-of-pocket expenses for a screening colonoscopy.

INCOME: $_____ Annual income. Your income and/or combined income if married.
_____Total number of people supported by this income.

Verified Income: (check one)

_____Two recent pay stubs **or**
_____Most recent U.S. tax return **or**
_____A signed statement from an employer stating the gross earned income or if this is not available, a self-declaration statement of cash earned.

Insurance:

_____ _____
Insurance Company Name Deductible/Copayment Amount

Please read the following and sign below indicating your understanding of the requirements:

- You may be eligible to receive 50% or more off your deductible/copayment for your screening colonoscopy service based upon the following criteria:

Patient Balance	**Applicable discount**
$100-500	**50% off co-pay amount**
$501 and greater	**$250 max. patient responsibility**

- You will be responsible for balances due for all physician services
- This program is based on the availability of donated funds.

_____
Applicant's Signature Date

_____
(Please print name)