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:

<table>
<thead>
<tr>
<th>Patient Balance</th>
<th>Applicable discount</th>
</tr>
</thead>
<tbody>
<tr>
<td>$100-500</td>
<td>50% off co-pay amount</td>
</tr>
<tr>
<td>$501 and greater</td>
<td>$250 max. patient responsibility</td>
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</table>

• 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)