Berkshire Health Systems
Application for Financial Assistance

BMC	
Fairview	
BFS	

1. PATIENT INFORMATION

Print the full name, address, and contact information of the person requesting assistance.

Name: _____

Last First Middle Initial

Address: _____

Number and Street City County

_____

State ZIP Code Country (if not USA)

Marital Status: ( ) Single ( ) Married ( ) Divorced

Date of Birth: _____ Social Security #: _____

Home Phone #: _____ Other Phone #: _____

2. FAMILY MEMBERS

List all family members living in your household. For the purposes of this application, family is defined as the applicant, the applicant's spouse, and all of the applicant's children under age 18 (biological, step, or adoptive) who live in the applicant's home. If the applicant is under the age of 18, the family will include the applicant, the applicant's biological, step, or adoptive parents, and the children of the applicant's parents under the age of 18 who also reside in the applicant's home.

Name of Family Member Date of Birth Relationship Social Security #

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

3. WAGES

Please provide documentation of all wages & tips listed.

Family Member	Amount	How often received?
1.	$	
2.	$	
3.	$	
4.	$	
5.	$	
6.	$	

4. OTHER INCOME

Please provide documentation of all income listed:

Type of Income	Household Member Receiving Benefit	Amount	How Often Received? (circle one)		
Social Security		$	Weekly	Monthly	Annually
Unemployment		$	Weekly	Monthly	Annually
Pension		$	Weekly	Monthly	Annually
Short or Long-Term Disability (not SSDI)		$	Weekly	Monthly	Annually
Veteran's Benefits		$	Weekly	Monthly	Annually
Child Support		$	Weekly	Monthly	Annually
Alimony		$	Weekly	Monthly	Annually
Net Rental or Royalty Income		$	Weekly	Monthly	Annually
Net Self-Employment Income		$	Weekly	Monthly	Annually
Trust Income		$	Weekly	Monthly	Annually
Annuities		$	Weekly	Monthly	Annually
Capital Gains		$	Weekly	Monthly	Annually
Interest, Dividend, or Investment income		$	Weekly	Monthly	Annually
Net Farming or Fishing Income		$	Weekly	Monthly	Annually
Taxable Military Retirement Pay (not VA)		$	Weekly	Monthly	Annually
Worker's Compensation		$	Weekly	Monthly	Annually
Other taxable income		$	Weekly	Monthly	Annually

5. COMMENTS/AFFIDAVIT OF SUPPORT

Use this section for additional information or your statement of support.

If you reported $0 income, please provide a brief explanation of how you (or the applicant) are meeting basic living needs:

_____

_____

6. HEALTH INSURANCE INFORMATION

Please provide information on Health Insurance Coverage.

Did you have health insurance at the time of your service? If yes, please provide your insurance information and a copy of your insurance card. ( ) Yes ( ) No

_____

Insurance Company Name ID Number Subscriber Name Effective Date

By my signing below, I certify that everything I have stated on this application and on any attachments is true to the best of my knowledge.

I agree to provide additional documentation upon request to determine my eligibility.

I am aware that falsification of any information provided may result in a denial of financial assistance.

I agree to tell the hospital of any change in my income, family size, health insurance coverage, or other information that may change my eligibility for Financial Assistance.

Signature of Applicant/Guarantor: X_____ Date:_____

Signature of Authorized Representative: X_____ Date:_____