



HARDSHIP APPLICATION	Office Use Only		Initials	Date
	Submitted			
	Approval (Office)			
	Approval (ED)			
	Comments			

Required - Applicant Information

Applicant Name:

Street Address:

City, State, Zip:

Mobile Phone: Home Phone: Other Phone:

Email:

Responsible Party Information (If other than patient)

Name: Relationship:

Address: Phone:

Required - Income Information (Please complete for each member of household, attach additional pages if needed)
****REMEMBER: proof of income is required with all applications****

Name	Relationship	Source of Income (i.e., Wages, Unemployment, Worker's Compensation, Disability, SSI, Pension, Retirement Distributions)	Gross Monthly Income
Patient (Applicant)			

Additional Information

\$ Monthly Public Assistance Benefits

\$ Work study programs (students)

\$ Child/spousal support

\$ Other – please explain:

Total Number of People Living in Household (required)

Required – Documentation – Please submit the following documentation with this application.

- Recent paycheck stubs (3 months); or
- Social Security benefit statement (current or previous year); or
- W-2 withholding statement (previous year); or
- Income tax return (previous year); or
- Bank statement (30-day period, current or previous month); and
- Documentation of any assistance as listed in the Additional Information section above.

Required – Patient Agreement

I hereby acknowledge that the information given here is true and correct to the best of my knowledge. I authorize Bennington Rescue Squad to verify any information contained in this document for the purpose of assessing financial need. I understand that income shall be analyzed from the date of request based on the documentation provided. All requests for financial hardship shall be kept confidential.

Print Name: Signature: Date: