



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

Applicant Information

First Name		Middle		Last	
Address					Apt#
City		State		Zip	
Mobile Phone #		Home Phone		Other Phone	
Email					

Responsible Party Information (If other than patient)

Name		Relationship	
Email		Phone	

Employer Information (Please complete for each member of household)

Name	Relationship	Employer (If unemployed, please indicate date of separation from employer. If a Minor, please write 'Minor' below)	Phone Number	Monthly Gross Income
Patient (Applicant)				

Additional Information

	Monthly Public Assistance Benefits
	Monthly Unemployment Benefits
	Monthly Social Security Benefits
	Monthly Worker's Compensation Benefits
	Monthly Child Support Received
	Other Monthly Income (Alimony, etc.)
	Total Number of People Living in Household

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

- Recent Pay Check Stubs
- W-2 Withholding Statements
- Income Tax Return
- Documentation of any assistance documented in the "Additional Information" section above.

Signature

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	
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