2021 Patient Assistance Application

Patients with Primary Insurance

Please call Angie with questions at 802-748-7518.

[Place Patient Label Here]
Instructions

Northeastern Vermont Regional Hospital’s staff understands the confusion surrounding healthcare today. We have designed this packet to make your application for Patient Assistance both easy and efficient. The process does require an investment of time. Please read carefully.

Applications must be completed in full and be accompanied by all required supporting documentation. Incomplete applications will remain unprocessed until all information is provided. Applications may be mailed back or a phone call requesting missing information may be made. Applications will be rejected if supporting documentation is not received within 14 days of request.

If you qualify: Since you already have healthcare insurance, simply complete the 2021 Patient Assistance Application and provide the necessary documentation.

Proof of Income:
1. Complete copy of most current tax return

In the event you do not file taxes: (one of the following)
2. Letter from employer confirming earnings
3. Three months of check stubs
4. Social Security Annual Notification of Payment

Documentation necessary for determination:
1. Copy of a recent bank statement for all accounts
2. Copy of property tax bill
3. Documentation of investment accounts from a broker or financial institution
4. Documentation of child support and/or alimony paid or received

Mail the completed application with proof of income and documentation to:

NVRH Attention: PA
PO Box 905
St. Johnsbury, VT 05819

Sincerely,

Mindy S. Vigeant
Mindy S. Vigeant, CRCS-P, CRCS-I
Director of Patient Accounts
Date: ________________

Applicant-
Last Name: __________________________ First Name: __________________________ Middle Initial: ______

Co-Applicant-
Last Name: __________________________ First Name: __________________________ Middle Initial: ______

Mailing Address: ____________________________________________________________

City: __________________________ State: ________ Zip Code: ______________________

Home Phone: __________________________ Work Phone: __________________________

Cell Phone: __________________________ Co-Applicant’s Cell: ______________________

**Household:** Household is defined as a group of two or more persons related by birth, marriage, civil union from Vermont Act 91, or adoption, who reside together and among whom there are legal responsibilities for support. Household further includes persons living together who present themselves and live as a couple.

<table>
<thead>
<tr>
<th>Household Member’s Name</th>
<th>Relationship to Applicant</th>
<th>Age</th>
<th>Employer or School Attending (if full-time student)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Self</strong></td>
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</tr>
</tbody>
</table>


**Income:** is defined as total annual cash receipts before taxes from all sources except as identified below.

**Income includes:**
1. Money from wages and salaries before any deductions
2. Net receipts from non-farm or farm self-employment
3. Regular payments from social security, railroad retirement, unemployment compensation, worker’s compensation, or strike benefits from union funds
4. Disability benefits, veteran’s benefits, public assistance including Aid to Families with Dependent Children, Supplemental Security Income and General Assistance money payments
5. Alimony, child support, and military family allotments or other regular support from an absent family member or someone not living in the household
6. Private pensions, government employee pensions, and regular insurance or annuity payments, dividends, interest, rents, royalties, periodic receipts from estates or trusts, net gambling, or lottery winnings.

**Income does not include the following:**
1. Tax refunds, gifts, loans and lump-sum inheritances
2. One-time insurance payment or other one-time compensation for injury
3. Non-cash benefits such as employee fringe benefits
4. The value of food and fuel produced and consumed on farms
5. Federal non-cash benefit programs such as food stamps, school lunches and housing assistance.

**List current or last employment (including Business or self-employment) for all household members:**

<table>
<thead>
<tr>
<th>Household Member</th>
<th>Employer</th>
<th>Hire Date</th>
<th>Term Date</th>
<th>Weekly GROSS income</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

**Income from other Sources:** Please list if you receive income from- Social Security, disability, retirement, alimony, pensions, renters, business interest, unemployment compensation, workers compensation, child support, friends, or relatives. *If none, please indicate how you support yourself.*

<table>
<thead>
<tr>
<th>Household Member</th>
<th>Type of Income</th>
<th>Monthly GROSS Income</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>
**Expenses:** Please list the total for your monthly expenses as they apply.

- **Home/Auto Insurance:** $___________________/month
- **Credit Cards:** $___________________/month
- **Automobile loan/lease:** $___________________/month
- **Mortgage/Rent:** $___________________/month
- **Medical (Dental, RXs):** $___________________/month
- **Fuel (Heat):** $___________________/month
- **Utilities (water,electric):** $___________________/month
- **Property Tax:** $___________________/month
- **Other Expenses:** $___________________/month
  Describe: ______________________________

**Assets:** List assets such as checking or savings accounts in bank and credit unions, stocks, bonds, mutual funds, bank CD’s, annuities, trust funds, or any other assets. If none, indicate “NONE”. Applicants with liquid assets of $50,000 or more will not be considered.

<table>
<thead>
<tr>
<th>Type, Person</th>
<th>Institution</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example: Checking, Sally Smith</td>
<td>Passumpsic Savings Bank, St. Johnsbury, VT</td>
<td>$</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$</td>
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<td></td>
<td></td>
<td>$</td>
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<tr>
<td></td>
<td></td>
<td>$</td>
</tr>
</tbody>
</table>

**Liabilities:** List liabilities such as mortgage and/or home equity loans, car loans, credit card balances or other debt. If none, indicate “NONE”.

<table>
<thead>
<tr>
<th>Type, Person</th>
<th>Institution</th>
<th>Balance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example: Mortgage, Sally Smith</td>
<td>Passumpsic Savings Bank, St. Johnsbury, VT</td>
<td>$</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$</td>
</tr>
</tbody>
</table>

**Real Estate:** Do you own real estate? No____ Yes____ If yes, list all real estate, including primary residence.

Location: __________________________________________ Assessed Value: $___________________

Location: __________________________________________ Assessed Value: $___________________
Insurance: Does the patient have medical insurance (Example: Medicaid or BC)? No _____ Yes _____
(if yes)
Insurance Name and ID Numbers: ____________________________________________________________
(if no)
Have you lost coverage in the last 3 months? No __________ Yes __________

Explain:
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Other Open Accounts with NVRH: List all open accounts for all family members for the affiliated
providers listed below: If not applicable write “NONE”.

<table>
<thead>
<tr>
<th>Provider</th>
<th>Account or Statement Number</th>
<th>Balance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Clinics</td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>Mental Health</td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>Hospital- ER, PT, OP.NPSPC</td>
<td></td>
<td>$</td>
</tr>
</tbody>
</table>

I certify, under penalties of law, that the above information is true and accurate to the best of my knowledge.
Furthermore, I will make application for any assistance, which may be available for payment of my hospital charge, and
I will take any action reasonable to obtain such assistance and will assign or pay to the hospital the amount recovered
for hospital charges. I understand this application is made so the hospital can judge my eligibility for uncompensated
services based on the established criteria on file in the hospital. If any information I have given proves to be untrue, I
understand that the hospital may re-evaluate my financial status and take whatever action is deemed appropriate to
include legal action.

This application is for NVRH HOSPITAL & NVRH PROVIDER PRACTICES services only.

Applicant’s Signature: ___________________________________________ Date: _______________

Co-Applicant’s Signature: _________________________________________ Date: _______________

_____________________________________ Please Do Not Write Below This Line______________________

Approved By: ___________________________ Date: __________________

Percentage: ___________________________ Ending: __________________

In making the determination of eligibility I have considered this patient’s income, expenses, assets and
liabilities.
Financial Assistance Application Checklist

- Complete copy of your most recent Federal Income Tax Return and all schedules and forms. (example: Schedule E needed for rental income)
- Copy of a recent bank statement for all accounts (savings, checking), must include bank name, client name, balance and current date.
- Copy of social security, disability compensation, pension and/or retirement income.
- Copy of current statement for investment accounts from broker or financial institution.
- Tax bill or tax assessment on property owned.
- Copy of unemployment benefits statement, if applicable.
- Documentation of child support and/or alimony paid or received.
- Signatures, applications cannot be processed without signatures from all adults in the household wishing to receive financial assistance.
- Entire application is filled out, if a section or question does not apply, please write “N/A” for not applicable.

Financial assistance is valid for 6 or 12 months depending on individual situations. The Financial Assistance Program at NVRH is not an insurance company and should not be applied for unless you have an outstanding balance that you cannot pay.

The following is a list of the providers rendering care at NVRH who are not covered under the financial assistance program:

- CardioNet
- Shippee Family Eye Care, P.C.
- iRT
- Preventice
- Orthocare
- Rom Tech
- Lab Services sent to the University of Vermont Medical Center
- Northern Counties Health Clinic providers
- VT Radiologists
Northeastern Vermont Regional Hospital

<table>
<thead>
<tr>
<th>Family Size</th>
<th>100% Reduction Up to 200% FPLG FAMILY INCOME LEVEL</th>
<th>85% Reduction 201%-250% FPLG FAMILY INCOME LEVEL</th>
<th>70% Reduction 251%-300% FPLG FAMILY INCOME LEVEL</th>
<th>57% Reduction 301%-350% FPLG FAMILY INCOME LEVEL</th>
<th>47% Reduction 351%-400% FPLG FAMILY INCOME LEVEL</th>
<th>Not Eligible &gt; 400% FPLG FAMILY INCOME LEVEL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assets</td>
<td>&lt;$50,000</td>
<td>&lt;$50,000</td>
<td>&lt;$50,000</td>
<td>&lt;$50,000</td>
<td>&lt;$50,000</td>
<td>&gt;$50,000</td>
</tr>
<tr>
<td>1</td>
<td>$1- $25,760</td>
<td>$25,761- $32,200</td>
<td>$32,201-$38,640</td>
<td>$38,641-$45,080</td>
<td>$45,081-$51,520</td>
<td>&gt;$51,520</td>
</tr>
<tr>
<td>2</td>
<td>$1- $34,840</td>
<td>$34,841- $43,550</td>
<td>$43,551-$52,260</td>
<td>$52,261-$60,970</td>
<td>$60,971-$69,680</td>
<td>&gt; $69,680</td>
</tr>
<tr>
<td>3</td>
<td>$1- $43,920</td>
<td>$43,921- $54,900</td>
<td>$54,901-$65,880</td>
<td>$65,881-$76,840</td>
<td>$76,861-$87,840</td>
<td>&gt; $87,840</td>
</tr>
<tr>
<td>4</td>
<td>$1- $53,000</td>
<td>$53,001- $66,250</td>
<td>$66,251-$79,500</td>
<td>$79,501-$92,750</td>
<td>$92,751-$106,000</td>
<td>&gt; $106,000</td>
</tr>
<tr>
<td>7</td>
<td>$1- $80,240</td>
<td>$80,241- $100,300</td>
<td>$100,301-$120,360</td>
<td>$120,361-$140,420</td>
<td>$140,421-$160,480</td>
<td>&gt; $160,480</td>
</tr>
<tr>
<td>8</td>
<td>$1- $89,320</td>
<td>$89,321- $111,650</td>
<td>$111,651-$133,980</td>
<td>$133,981-$156,310</td>
<td>$156,311-$178,640</td>
<td>&gt; $178,640</td>
</tr>
<tr>
<td>9</td>
<td>$1- $98,400</td>
<td>$98,401- $123,000</td>
<td>$123,001-$147,600</td>
<td>$147,601-$172,200</td>
<td>$172,201-$196,800</td>
<td>&gt; $196,800</td>
</tr>
<tr>
<td>10</td>
<td>$1- $107,480</td>
<td>$107,481- $134,350</td>
<td>$134,351-$161,220</td>
<td>$161,221-$188,090</td>
<td>$188,091-$214,960</td>
<td>&gt; $214,960</td>
</tr>
</tbody>
</table>

2021 Patient Assistance Guidelines