Choosing Health

Northeastern Vermont Regional Hospital

2024 Patient Assistance Application

Medicare or Self-Pay Patients

Please call Angie with questions at 802-748-7518

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[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: If you are a resident of Vermont or New Hampshire, complete the application for Medicaid for the state you reside in. Once the application for Medicaid has been processed, you will receive a Notice of Decision from the state. The Notice of Decision and necessary documentation must be attached to the completed Patient Assistance application before it can be processed. Incomplete applications will be returned to the sender until completed.

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 your Notice of Decision from the state
2. Copy of a recent bank statement for all accounts
3. Copy of property tax bill
4. Documentation of investment accounts from a broker or financial institution
5. 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 married couple.

Household Member's Name	Relationship to Applicant	Age	Employer or School Attending (if full-time student)
	Self		

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:

Household Member	Employer	Hire Date	Term Date	Weekly GROSS income

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.***

Household Member	Type of Income	Monthly GROSS Income

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.

Type, Person Example: Checking, Sally Smith	**Institution** Passumpsic Savings Bank, St. Johnsbury, VT	**Value**
		$
		$
		$
		$

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

Type, Person Example: Mortgage, Sally Smith	**Institution** Passumpsic Savings Bank, St. Johnsbury, VT	**Balance**
		$
		$
		$
		$

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"**.

Provider	Account or Statement Number	Balance
Community Clinics		$
Mental Health		$
Hospital- ER, PT, OP.NPSPC		$

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 Notice of Decision from the State of VT or NH
- 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
- Boston Scientific Cardiac Diagnostics, Inc.
- Orthocare
- Rom Tech
- Lab Services sent to the University of Vermont Medical Center
- Northern Counties Health Care providers
- VT Radiologists

Northeastern Vermont Regional Hospital

Family Size	100% Reduction Up to 200% FPLG FAMILY INCOME LEVEL	85% Reduction 201%-250% FPLG FAMILY INCOME LEVEL	70% Reduction 251%-300% FPLG FAMILY INCOME LEVEL	57% Reduction 301%-350% FPLG FAMILY INCOME LEVEL	47% Reduction 351%-400% FPLG FAMILY INCOME LEVEL	Not Eligible > 400% FPLG FAMILY INCOME LEVEL
Assets	**<$50,000**	**<$50,000**	**<$50,000**	**<$50,000**	**<$50,000**	
1	$1- $30,120	$30,121- $37,650	$37,651-$45,180	$45,181-$52,710	$52,711-$60,240	>$60,240
2	$1- $40,880	$40,881- $51,100	$51,101-$61,320	$61,321-$71,540	$71,541-$81,760	> $81,760
3	$1- $51,640	$51,641- $64,550	$64,551-$77,460	$77,461-$90,370	$90,371-$103,280	>$103,280
4	$1- $62,400	$62,401- $78,000	$78,001-$93,600	$93,601-$109,200	$109,201-$124,800	>$124,800
5	$1- $73,160	$73,161- $91,450	$91,451-$109,740	$109,741-$128,030	$128,031-146,320	>$146,320
6	$1- $83,920	$83,921- $104,900	$104,901-$125,880	$125,881-$146,860	$146,861-$167,840	> $167,840
7	$1- $94,680	$94,681-$118,350	$118,351-$142,020	$142,021-$165,690	$165,691-$189,360	> $189,360
8	$1- $105,440	$105,441- $131,800	$131,801-$158,160	$158,161-$184,520	$184,521-$210,880	> $210,880
9	$1- $116,200	$116,201- $145,250	$145,251-$174,300	$174,301-$203,350	$203,351-$232,400	> $232,400
10	$1- $126,960	$126,961- $158,700	$158,701-$190,440	$190,441-$222,180	$222,181-$253,920	> $253,920

2024 Patient Assistance Guidelines