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. Please note there must be two documents that show a physical address. Incomplete applications will be returned to the sender to be 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. 30 days of paystubs
4. Social Security Annual Notification of Payment
5. Bank Statement
6. Profit and Loss Statement
7. Self-attestation in extenuating circumstances in which no other documentation is available

Documentation necessary for determination:

1. Copy of a recent bank statement for all accounts
2. Copy of property tax bill **for second homes/vacation homes**
3. Documentation of investment accounts from a broker or financial institution
4. Documentation of child support and/or alimony paid if you would like NVRH to consider your living expenses

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: _____

Spouse or Domestic Partner
Last Name: _____ First Name: _____ Middle Initial: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Co-Applicant's Cell: _____

Household: List spouse or domestic partner and all tax dependents. If you don't file taxes, please list the people who would be your tax dependents if you filed.

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. Gross wages/salary
2. Net receipts from non-farm or farm self-employment
3. Regular payments from social security, railroad retirement, unemployment compensation, or strike benefits from union funds if taxable.
4. Disability benefits
5. Military family allotments or other regular support from an absent family member or someone not living in the household, if taxable
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, pensions, renters, business interest or unemployment compensation. ***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:** _____

Liquid Assets: List liquid assets such as checking or savings accounts in bank and credit unions, stocks, bonds, mutual funds, bank CD's, annuities (if liquid), trust funds (if liquid), or any other liquid assets. If none, indicate "**NONE**". Applicants with liquid assets of 400% of the Federal Poverty Level 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 a second home, vacation home, seasonal residence or camp? No____ Yes____

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. 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

- Proof of Income
- Copy of a recent bank statement for all accounts
- Copy of current statement for investment accounts from broker or financial institution
- Tax bill or tax assessment on second properties owned.
- Documentation of child support and/or alimony paid
- 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
- Enovis/Surgi-Care
- 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 250% FPLG FAMILY INCOME LEVEL	70% Reduction 251%-300% FPLG FAMILY INCOME LEVEL	60% Reduction 301%-350% FPLG FAMILY INCOME LEVEL	50% Reduction 351%-400% FPLG FAMILY INCOME LEVEL	Not Eligible > 400% FPLG FAMILY INCOME LEVEL
Assets	**<400% FPLG**	**<400% FPLG**	**<400% FPLG**	**<400% FPLG**	
1	$1- $37,650	$37,651-$45,180	$45,181-$52,710	$52,711-$60,240	>$60,240
2	$1- $51,100	$51,101-$61,320	$61,321-$71,540	$71,541-$81,760	> $81,760
3	$1- $64,550	$64,551-$77,460	$77,461-$90,370	$90,371-$103,280	>$103,280
4	$1- $78,000	$78,001-$93,600	$93,601-$109,200	$109,201-$124,800	>$124,800
5	$1- $91,450	$91,451-$109,740	$109,741-$128,030	$128,031-146,320	>$146,320
6	$1- $104,900	$104,901-$125,880	$125,881-$146,860	$146,861-$167,840	> $167,840
7	$1-$118,350	$118,351-$142,020	$142,021-$165,690	$165,691-$189,360	> $189,360
8	$1- $131,800	$131,801-$158,160	$158,161-$184,520	$184,521-$210,880	> $210,880
9	$1- $145,250	$145,251-$174,300	$174,301-$203,350	$203,351-$232,400	> $232,400
10	$1- $158,700	$158,701-$190,440	$190,441-$222,180	$222,181-$253,920	> $253,920

2024 Patient Assistance Guidelines