University of Vermont Health

Financial Assistance Program

customerservice@uvmhealth.org

Need Help Completing the Application: Call us at 800-639-2719

Financial Assistance Application

Please select the location for services (please select all that apply)

☐ Central Vermont Medical Center ☐ Porter Medical Center ☐ UVM Medical Center

Head of Household / Financial Guarantor Information

Head of Household			
Date of Birth	**Social Security #**	**Marital Status**	**Phone Number**

Address	City	State	Zip Code

Household Members

List all family members who live in your household including a domestic partner. Domestic partner means a person who lives with you in a committed relationship. A partner does not include a roommate.

Name	Date of Birth	Social Security #	Relationship

Additional Information

Are you covered under any health insurance policy? If yes, provide information below:		☐ Yes ☐ No
Insurance Company Name:	ID #:	
Have you applied for coverage for Vermont or New York Medicaid?		☐ Yes ☐ No
Have you applied for coverage with the Vermont or New York Health Exchange?		☐ Yes ☐ No
Do you live in, work in, or go to school in Vermont?		☐ Yes ☐ No

Monthly Expenses

We use this information to better understand your finanical situation

Rent or Mortgage	$:	Medications	$:
Property Tax	$:	Health Insurance	$:
Utilities (water / electric)	$:	Healthcare Bills	$:
Auto (car payment)	$:	Insurance (Auto / Property)	$:
Child Care	$:	Alimony / Child Support	$:
Living (food / gas)	$:	Other	$:

Continue application on the reverse side

Employment

	Head of Household / Financial Guarantor	Spouse / Domestic Partner
Employer or circle if: (retired / student / unemployed)		

Monthly Income

Gross Salary Wage	$:	$:
Self-Employment Income	$:	$:
Social Security	$:	$:
Pension / Retirement Distribution	$:	$:
Disability (excludes VA)	$:	$:
Unemployment	$:	$:
Rental Income	$:	$:
Dividend Income	$:	$:
Other Income:	$:	$:

Liquid Assets
Cash / Savings / Investments

	Head of Household / Financial Guarantor	Spouse / Domestic Partner
Checking	$:	$:
Savings	$:	$:
CD	$:	$:
Stocks / Mutual Funds	$:	$:
Bonds	$:	$:
Annuities (if liquid)	$:	$:
Money Market	$:	$:
Trust Account (if liquid)	$:	$:
Other:	$:	$:

Additional Property
(Does not include your primary residence)

	Value	Mortgage Balance
Vacation / Second Home	$:	$:
Land	$:	$:
Rental Property	$:	$:

Please include any other information about your current financial situation that you would like us to know. Such as difficulty paying for bills, rent, or food.

Complete and sign application on the following page

Documentation Checklist

Please mail your completed application, along with supporting documentation to our Financial Assistance Programs at the hospital where you receive your care. Qualification for assistance is based upon a series of criteria including an income and assets test. To process your application, please provide the applicable documentation listed below to support your financial need.

Income:

- Most recent federal income tax return
- In lieu of the federal income tax return, you may submit the alternatives listed below:
    - Employed / Self Employed:
        - Two most recent, consecutive earnings statements (pay stubs)
        - Written income verification from an employer (if paid in cash)
        - Written confirmation of migrant worker contract
        - Written confirmation from the Open-Door Clinic
    - Social Security: Current year benefit verification letter -or- most recent 1099-SSA statement
    - Pension/Retirement Distribution: Current benefit statement -or- most recent 1099-R statement
    - Unemployment: Current benefit statement
    - Rental Income: Year-to-date profit and loss statement if property is not included in assets
    - Documentation of public assistance (i.e., Medicaid, food stamps, etc.)

Liquid Assets:

- Current statement from your financial institute for:
    - Checking and Savings
    - Certificate of Deposit (CD)
    - Stocks / Mutual Funds / Bonds / Money Market
    - Annuities, if liquid
    - Rental Property (if rental income is not included in your federal income tax return)

Please Read Carefully

I am requesting financial assistance from the Vermont partners of the University of Vermont Health Network. I verify that all information I have provided is accurate and complete. The University of Vermont Health Network has my permission to pursue verification of pertinent information and exchange information regarding my accounts, application and supporting documentation with its affiliated providers. Any incorrect, incomplete or false information provided may cancel my application for financial assistance. I agree to repay the full financial assistance award if I receive payment of any kind for the medical services covered by this financial assistance application. All information provided will remain confidential under the provisions of HIPAA federal regulations.

Signature of Head of Household / Financial Guarantor	Date

Please mail your completed application to the address below. Please ensure you attach the required documentation to the application.

University of Vermont Medical Center
Financial Assistance Program
Patient Access Department IDX 22052
111 Colchester Avenue
Burlington, VT 05401