THE University of Vermont MEDICAL CENTER

Patient Financial Assistance Program
PO Box 1810, Burlington, Vermont 05402
802-847-8000, 800-639-2719
Fax: 802-847-7618
customerservice@uvmhealth.org

Dear Applicant,

Thank you for choosing The University of Vermont Medical Center as your health care provider.

If payment of your medical bills creates a financial hardship for you, you may be eligible for financial assistance through The University of Vermont Medical Center's Patient Financial Assistance Program. Our staff are here to help you and are willing to work through the process with you. Please note that before any financial assistance can be provided by The University of Vermont Medical Center, our staff will work with you to identify other sources of payment.

The following criteria must be met to be eligible for financial assistance from The University of Vermont Medical Center:

- You must be a permanent resident within The University of Vermont Medical Center service area which includes all of Vermont, and Clinton, Essex, Franklin, Hamilton, St. Lawrence, Warren, and Washington counties of New York, and selective counties and services within New Hampshire. If you live outside the service area you are not eligible for The University of Vermont Medical Center financial assistance unless your services were documented as urgent or were provided on an emergency basis.

- The services that were provided to you must be considered medically necessary essential health care services.

- The following types of services are not considered medically necessary and are excluded from the program:
  - Cosmetic services - unless medically necessary based upon diagnosis with physician review.
  - Birth control, infertility treatments, fertility services, sterilization and reversal of sterilization.
  - Services that have been placed in Collections beyond 120 days of placement.
  - Services reimbursed directly to you by your insurance carrier or already covered by another third party.

- Household income and assets/resources must be within income and asset guidelines (see last page).

If you meet the criteria and wish to apply for The University of Vermont Medical Center Patient Financial Assistance Program, please complete the enclosed application form. Please note, you will continue to be financially responsible for all services you receive until it is determined you qualify for assistance.

We are here to help, if you have any questions or require aid in understanding any part of the application process please contact a member of our Customer Service team at 802-847-8000 or 800-639-2719, or contact us by email at: customerservice@uvmhealth.org. Completed applications should be forwarded to the following address:

The University of Vermont Medical Center
Patient Financial Assistance Program
PO Box 1810
Burlington, Vermont 05402

Form 036685 - Revised March 16, 2015

For Your Convenience - Our Documentation Check List

To determine if you qualify for assistance, you will need to show proof of your income, and also supply documentation necessary for determination. Please fill out the attached application in full, sign it, and send the application along with a copy of each of the following documentation (those that are applicable) for your household:

Note: If sending Bank Statement or Online documentation, copies must include the bank name, client name, balance and current date.

1.) Complete copy of your most recent Federal Income Tax Return and all schedules and forms, e.g. 1040, 1099 etc. Note: Cannot substitue W2's, summaries, etc.. ☐

2.) Self-employed/Sole Proprieter must provide complete documentation of the following:

a.) Federal Tax Returns and Year to Date Profit and Loss statement ☐

b.) Partnership: All of the above, plus Partnership Federal Tax Return ☐

c.) Corporation: All of the above, plus Corporation Federal Tax Return ☐

3.) Copies of the two (2) most recent, consecutive paycheck stubs or a statement from the employer ☐

4.) Copy of one (1) most recent bank statement, (e.g., savings, checking, money market, etc.) ☐

5.) Copy of unemployment benefits statement if applicable (e.g., check, bank statement, online, etc.) ☐

6.) Copy of disability compensation benefit statement/award letter (e.g., check, bank statement, online, etc.) ☐

7.) Copy of social security, pension, retirement income (e.g., award letter, check stub, bank statement, etc.) ☐

8.) Documentation of child support and/or alimony paid or received (e.g.,cancelled check, garnishment, bank statement, etc.) ☐

9.) Investment accounts - copies of current or quarterly statement from broker or financial institution ☐

10.) Real Estate - tax assessment or tax bill, and mortgage balance statement on property owned, excluding primary residence ☐

11.) Rental Income - Copy of current Schedule E of IRS form ☐

12.) Appraisal for recreational vehicle from www.nadaguides.com and bank loan statement if applicable ☐

13.) If an application for state assistance, (e.g. Medicaid, State Health Exchange) has been made in the last 60 days and you have received a decision, please provide a copy ☐

14.) If proof of residency is required, please send one of the following: VT/NY/NH driver's license, property tax bill, lease for property, or a utility bill ☐

15.) Other: _____ ☐

Please use the above checklist to be sure we have all the information we need to quickly and correctly process your application. It is important that your application be complete, and that all necessary documentation is received. All information you provide to us is confidential.

Questions & Answers and Information You Should Know…

Can I get help completing my application?

Yes. Please contact Customer Service at 847-8000 or 1-800-639-2719 with questions, or email us at customerservice@uvmhealth.org. If you would like to speak to a representative in person our Financial Service Office is located at the Main Campus, MCHV, Level 3. The staff at the Health Assistance Program are also available to meet with you to complete the application. Please call them at 802-847-6984 to make an appointment.

If a question or section does not pertain to me, can it be left blank?

No. We cannot assume an unanswered question or section means it does not apply to you. One of the requirements when applying for financial assistance with The University of Vermont Medical Center is a complete application. If a section or question does not apply, write "N/A" for not applicable.

I don't have all the documentation requested but the application is due back. Can I send what I have?

No. You must return a complete application with all the appropriate documentation or the application will be returned as denied. Extension will only be made on a case by case basis for extenuating circumstances and must be requested by contacting Customer Service or the Patient Financial Assistance Program Specialist.

What is a tax assessment?

This is the tax bill you get yearly from your town clerk or City Hall office. It will say "Tax Bill" or "Property Tax Bill" at the top of the page. It gives the current housesite value, housesite municipal tax and housesite education tax values.

Where do I get the "book" value or loan value for my recreational vehicle?

If you have access to a computer and the Internet, you may go online to look up the year, make and model for an estimate at www.nadaguides.com. If you do not have access to a computer contact a local dealer. Please provide written documentation.

Why was the verification I sent for my bank account(s) not accepted?

We require a copy of the original bank statement(s). If this is not available we will only accept a substitute statement which has the following: bank name, client name, type of account, current date, and current balance. Each of these items must be printed on bank letterhead and not hand written.

What is a benefit award letter?

If you are receiving social security or disability benefits, this is the yearly letter that social security sends notifying you of your monthly eligible benefits. For verification purposes we will accept a copy of the benefit award letter, a copy of your social security (disability) check or if you have direct deposit we will accept your bank statement showing your social security deposit as verification. Whichever verification is used, the monthly eligibility benefits should match the amount given on the application.

Questions & Answers and Information You Should Know..., continued

I sent my W2's then I received my application back asking for my Federal Tax Return. Why?

There is a difference between your W-2's and your Federal Tax Return. A W-2 is simply a statement of your earnings. Your Federal Tax Return is a complete recording of your total income. We require a copy of your Federal Tax Return. W-2's cannot be used as a substitute. We also do not accept summaries from your eFiles of Federal Tax Returns. If you do not have a copy of your Federal Tax Return contact the Internal Revenue Service (IRS) at 1-800-908-9946 and request a tax return transcript at no cost.

What year of my Federal Tax Return do I send?

Provide the most current year - after April 15th.

My employer does not provide pay stubs, what should I do?

If pay stubs are not provided by your employer, an affidavit on letterhead from the company you work for will be accepted. The affidavit must show gross pay, deductions, and net pay for one month. Please note, if you are married or have a civil union partner, his / her verification is also required.

I do not complete a quarterly profit and loss for my business. Can I just send my current Federal Tax

If you are a self employed sole proprietor, Partnership, or Corporation, you will need to provide us with the most current Federal Tax Return and the current year quarterly profit and loss statement. Even though your business may not complete a profit and loss, it is a requirement when you apply for the Patient Financial Assistance Program. If you are filing as a Partnership or Corporation we will need these Federal Tax Returns, your personal Federal Tax Returns, along with the Partnership and/or Corporation Year-to-Date, Quarterly Profit and Loss.

What is the coverage period for Patient Financial Assistance?

Financial Assistance is valid for up to six months and may include coverage to current balances unless otherwise noted. Your coverage period will be indicated on your grant letter. If your income indicates you may be eligible for Medicaid, NY Family Health Plus or another insurance program funded by the State, you will only be granted financial assistance for current charges until a Medicaid application is made and a notice of decision letter is received by the Patient Financial Assistance Program Specialist.

How often do I need to re-apply for financial assistance?

The Patient Financial Assistance Program at The University of Vermont Medical Center is not an insurance company or a program such as Medicaid, or NY Family Health Plus. We are here to assist patients who face financial hardship and are unable to pay their bills. Financial Assistance should only be applied for if you have outstanding Fletcher Allen medical bills you cannot pay, expectation that an account currently pending insurance will leave a balance, or expectation that a future scheduled service will leave you a balance.

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Patient Financial Assistance Application

Applicant's Information:

Applicant Last Name	First Name	Middle Initial	Social Security Number	Date of Birth

Address	City	State	Zip code	Home Phone Number	Medical Record #

Employer or check one: ☐student ☐unemployed ☐disabled ☐retired

Marital Status - please check one: ☐single ☐married ☐separated ☐divorced ☐widowed

Spouse Last Name	Spouse First Name	Middle Initial	Social Security Number	Date of Birth

Spouse Employer or check one: ☐student ☐unemployed ☐disabled ☐retired

Household Information:

Please list below all dependents who live in your household.
It is not necessary to include non dependents who reside in your household.
Note: You may include dependent students (21 & under) for which you provide at least 50 % support and who are reflected as dependents on your Federal Income Tax Returns.

Last Name	First Name	Social Security #	Relation to Applicant	Date of Birth

Monthly Household Expenses:
This information is not required, but may be useful in making a determination

Rent Payment $ _____ OR Mortgage Loan Payment $ _____

Property Tax Amount Not Included in Payment Amount Above: $ _____

Do You Own Property Other Than Primary Residence? ☐ Yes ☐ No If Yes, Monthly Loan Payment: $ _____

Utilities	$ _____	Credit Card	$ _____	Insurance (Auto/Life/Property)	$ _____
Auto	$ _____	Health Insurance	$ _____	Alimony/Child Support	$ _____
Child Care	$ _____	Healthcare Bills	$ _____	Other: _____	$ _____
Living (gas, food, etc.)	$ _____	Medications	$ _____	Other: _____	$ _____

Additional Information:

Are you covered under any health insurance policy? ☐Yes ☐No

If yes, list insurance(s): _____

Are you seeking financial assistance for services resulting from any of the following: ☐Yes ☐No

☐ Work Related ☐ Liability ☐ Motor Vehicle

Do you have an application pending for insurance on the Health Exchange or State Aid such as Medicaid, or NY Family Health Plus? ☐Yes ☐No

Did you file and/or are you required to file a Federal Tax return? You must provide copies of your current Federal Income Tax Returns. ☐Yes ☐No

If no, why? _____

Do you reside in Vermont or New York greater than 6 months per year? ☐Yes ☐No

Assets and Income

REAL ESTATE owned other than primary residence. Please check those that apply, or check 'Not applicable'

Note: Tax assessment/tax bill and mortgage balance statement, if applicable. Attach separate list if multiple properties exist.

☐Vacation Home ☐Second Home ☐Land ☐Not applicable Value: $

Location (address): Mortgage Balance: $

☐Rental Property ☐Not applicable Value: $

Location (address): Mortgage Balance: $

RECREATIONAL VEHICLES owned: Please check those that apply, or check 'Not applicable'

☐Boat	Value: $	Loan Balance: $	Not applicable ☐
☐Camper	Value: $	Loan Balance: $	Not applicable ☐
☐ATV / Snowmobile	Value: $	Loan Balance: $	Not applicable ☐

Monthly Income From:	**Person 1**	**Person 2**	
Name of household member:			Documentation required for verification:
Gross Salary Wages	$	$	2 consecutive pay stubs / employer pay statement
Self Employed	$	$	Tax Return plus current YTD Profit & Loss
Social Security	$	$	Award letter, check stub, bank statement, etc
Workers' Compensation	$	$	Check, bank statement, online, etc
Unemployment	$	$	Check, bank statement, online, etc
Alimony / Child Support	$	$	Cancelled check, garnishment, bank statement, etc
Pension / Retirement Income	$	$	Bank Statement or Pension check stub
Disability	$	$	Check, bank statement, online, etc
Rental Income	$	$	Schedule E of IRS tax form
Dividend Income	$	$	Current/quarterly statement from financial institution
Other Income:	$	$	Contact PAP Specialist
Total:	**$**	**$**	

Cash, Savings and Investments:			
Checking Account Balances	$	$	Bank statement
Savings	$	$	Bank statement
CD Account Balances	$	$	Copy of statement
Bonds	$	$	Copy of statement or bond
Annuities	$	$	Copy of statement
Money Market	$	$	Copy of statement
Trust Account	$	$	Copy of statement
Stocks	$	$	Copy of statement
Mutual Funds	$	$	Copy of statement
Other - Specify: _____	$	$	Contact PAP Specialist
Total:	**$**	**$**	

Please Read Carefully

I am requesting financial assistance from The University of Vermont Medical Center. I verify that all information I have provided is accurate and complete. The University of Vermont Medical Center has my permission to pursue verification of pertinent information and 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 finanical assistance application. The University of Vermont Medical Center is authorized to access credit bureau files and reports, now and in the future for collection purposes. This authorization is given pursuant to Title 9, Sec.2480e of VT Statutes. All information provided will remain confidential under the provisions of HIPAA federal regulations.

Signature of Patient (or Parent / Guardian if Patient is under 18) Date

2015 Income and Asset Guidelines

To be eligible for financial assistance from The University of Vermont Medical Center, your income and assets should be at or below the monthly guidelines below. Some items such as your primary residence and non-recreational vehicles are not considered assets for this purpose. If your income and/or assets exceed the guidelines (400%) but you have extenuating circumstances, an application may be considered when submitted with a letter explaining your extenuating circumstances.

You must be a permanent resident within The University of Vermont Medical Center service areas: All of **Vermont** and **Clinton, Essex, Franklin, Washington, Hamilton, Warren,** and **St. Lawrence Counties of New York** and s**elective counties** and **services** within **New Hampshire.**

In order to manage our resources responsibly and to allow The University of Vermont Medical Center to provide the appropriate level of assistance to the greatest number of persons in need, The University of Vermont Medical Center has implemented a policy with guidelines to provide assistance based upon a sliding fee scale. Balances after the financial assistance percentage have been applied shall remain the responsibility of the patient and shoud be paid promptly.

Federal Poverty Level	**Less than 200%**	**201% - 250%**	**251% - 300%**	**301% - 350%**	**351% - 400%**	**Assets Limits**
Grant Discount	**100%**	**85%**	**75%**	**65%**	**55%**	**400% FPLG**
Household Size:						
1 Person	< $1,962	< $2,452	< $2,942	< $3,433	< $3,923	$8,000.00
2 Persons	< $2,655	< $3,319	< $3,983	< $4,646	< $5,310	$12,000.00
3 Persons	< $3,348	< $4,185	< $5,023	< $5,860	< $6,697	$12,600.00
4 Persons	< $4,042	< $5,052	< $6,062	< $7,073	< $8,083	$13,200.00
5 Persons	< $4,735	< $5,919	< $7,103	< $8,286	< $9,470	$13,800.00
6 Persons	< $5,428	< $6,785	< $8,143	< $9,500	< $10,857	$14,400.00
7 Persons	< $6,122	< $7,652	< $9,182	< $10,713	< $12,243	$15,000.00
8 Persons	< $6,815	< $8,519	< $10,223	< $11,926	< $13,630	$15,600.00
9 Persons	< $7,508	< $9,385	< $ 11,263	< $13,140	< $15,017	$16,200.00
10 Persons	< $8,202	< $10,252	< $12,302	< $14,353	< $16,403	$16,800.00
11 Persons	< $8,895	< $11,119	< $13,343	< $15,566	< $17,790	$17,400.00
12 Persons	< $9,588	< $11,985	< $14,383	< $16,780	< $19,177	$18,000.00
13 Persons	< $10,282	< $12,852	< $15,422	< $17,993	< $20,563	$18,600.00
14 Persons	< $10,975	< $13,719	< $16,463	< $19,206	< $21,950	$19,200.00
15 Persons	< $11,668	< $14,585	< $17,503	< $20,420	< $23,337	$19,800.00

Revised February 01, 2015

These guidelines are subject to change at any time.