

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 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 financial eligibility area which includes all of Vermont, and Clinton, Essex, Franklin, Hamilton, St. Lawrence, Warren, and Washington counties of New York, and for laboratory only, in New Hampshire Coos, Grafton, and Sullivan.

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

The following types of services are not eligible for financial assistance

- 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
- General dentistry unless extenuating circumstances are presented by the dental practice
- Services to residents outside of the financial eligibility area unless provided in an emergency room setting
- Services reimbursed directly to you by your insurance carrier or already covered by a third party

Household income and assets must be within guidelines

If you meet the criteria and wish to apply for The University of Vermont Medical Center 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. For help in completing the application, a Customer Service Representative or Financial Advocate is available M-F, 8:30 am - 4:30 pm at the UVM Medical Center main campus, Financial Services office, 111 Colchester Avenue, Burlington, VT 05401. Completed applications should be forwarded to the following address:

**The University of Vermont Medical Center
Financial Assistance Program
111 Colchester Avenue
1 South Prospect St. Campus, 2nd Floor
Burlington, Vermont 05401**

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 substitute W2's, summaries, etc.. ☐
- 2.) Self-employed/Sole Proprietor 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. Required during open enrollment. ☐
- 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, 111 Colchester Avenue, Burlington, VT 05401. 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 rejected unless supporting documentation is returned. Extension will only be made on a case by case basis for extenuating circumstances and must be requested by contacting Customer Service or the 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 or visit www.irs.gov/Individuals/Get-transcript

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 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 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 Financial Assistance Program Specialist. If you are over the age of 65 and are on a fixed income, you may be granted coverage up to one year.

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

The 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 medical bills you cannot pay with The University of Vermont Medical Center; expectation that an account currently pending insurance will leave a balance, or expectation that a future scheduled service will leave you a balance.

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: <input type="checkbox"/> Student <input type="checkbox"/> Unemployed <input type="checkbox"/> Disabled <input type="checkbox"/> Retired			
Marital Status - please check one:	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			
Spouse Last Name	Spouse First Name	Middle Initial	Social Security Number	Date of Birth
Spouse Employer	or check one: <input type="checkbox"/> Student <input type="checkbox"/> Unemployed <input type="checkbox"/> Disabled <input type="checkbox"/> Retired			

Household Information:

Please list below all dependents who live in your household. Do not include non-dependents who reside in your household.
Note: You may include dependents 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 Expenses:

Rental or Mortgage Payment: _____ Real Estate Debt: _____

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

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

Extenuating Expense Circumstances: _____

Additional Information:

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

If yes, list insurance(s): _____

If no, answer next question:

Did you enroll with Vermont Health Connect/NY Health Exchange/Medicaid? ☐ Yes ☐ No

Date: _____ Final eligibility determination letter will be required.

If no, reason: _____

Did you file and/or are you required to file a Federal Income Tax Return? ☐ Yes ☐ No

You must provide copies of your current Federal Income Tax Return.

If no, reason: _____

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

Do you have outstanding balances with any of the UVM Health Network partners? ☐ Yes ☐ No

<input type="checkbox"/> Alice Hyde Medical Center	<input type="checkbox"/> Central Vermont Medical Center
<input type="checkbox"/> Champlain Valley Physicians Hospital	<input type="checkbox"/> Elizabethtown Hospital

Assets, Liabilities 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: \$ _____

OTHER ASSETS AND LIABILITIES: 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 ☐

☐ All Other Debt 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 FAP 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 / Mutual Funds \$ _____ \$ _____ Copy of statement

Other - Specify: _____ \$ _____ \$ _____ Contact FAP 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 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. 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

2019 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 shown 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 **selective 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 any financial assistance has been applied shall remain the responsibility of the patient and should be paid promptly.

FPLG	Less than 200%	201% - 250%	251% - 300%	301% - 350%	351% - 400%	
Financial Assistance Percentage	100%	85%	75%	65%	55%	Asset Limits
Household Size*						
1 Person	\$2,082	\$2,602	\$3,123	\$3,643	\$4,163	\$50,000.00
2 Persons	\$2,818	\$3,523	\$4,228	\$4,932	\$5,637	\$50,000.00
3 Persons	\$3,555	\$4,444	\$5,333	\$6,221	\$7,110	\$50,000.00
4 Persons	\$4,292	\$5,365	\$6,438	\$7,510	\$8,583	\$50,000.00
5 Persons	\$5,028	\$6,285	\$7,543	\$8,800	\$10,057	\$50,000.00
6 Persons	\$5,765	\$7,206	\$8,648	\$10,089	\$11,530	\$50,000.00
7 Persons	\$6,502	\$8,127	\$9,753	\$11,378	\$13,003	\$50,000.00
8 Persons	\$7,238	\$9,048	\$10,858	\$12,667	\$14,447	\$50,000.00
9 Persons	\$7,975	\$9,969	\$11,963	\$13,956	\$15,950	\$50,000.00
10 Persons	\$8,712	\$10,890	\$13,068	\$15,256	\$17,423	\$50,000.00
11 Persons	\$9,448	\$11,810	\$14,173	\$16,535	\$18,897	\$50,000.00
12 Persons	\$10,185	\$12,731	\$15,278	\$17,824	\$20,370	\$50,000.00
13 Persons	\$10,922	\$13,652	\$16,383	\$19,113	\$21,843	\$50,000.00
14 Persons	\$11,658	\$14,573	\$17,488	\$120,402	\$23,317	\$50,000.00
15 Persons	\$12,395	\$15,494	\$18,593	\$21,691	\$24,790	\$50,000.00

Discrimination is Against the Law

The University of Vermont Medical Center complies with applicable federal civil rights laws and does not discriminate, exclude people or treat them differently on the basis of race, color, sex, sexual orientation, gender identity or expression, ancestry, place of birth, HIV status, national origin, religion, marital status, age, language, socioeconomic status, physical or mental disability, protected veteran status or obligation for service in the armed forces.

THE UVM MEDICAL CENTER PROVIDES FREE AIDS AND SERVICES TO DEAF PEOPLE AND PEOPLE WITH DISABILITIES TO COMMUNICATE EFFECTIVELY WITH US, SUCH AS:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

If you need these services, call (802) 847-3553.

THE UVM MEDICAL CENTER PROVIDES FREE LANGUAGE SERVICES TO PEOPLE WHOSE PRIMARY LANGUAGE IS NOT ENGLISH, SUCH AS:

- Qualified interpreters
- Information written in other languages

If you need these services, call (802) 847-8899.

If you believe that the UVM Medical Center has failed to provide these services or discriminated in another way on the basis of race, color, sex, sexual orientation, gender identity or expression, ancestry, place of birth, HIV status, national origin, religion, marital status, age, language, socioeconomic status, physical or mental disability, protected veteran status or obligation for service in the armed forces, you can file a grievance with:

Office of Patient and Family Advocacy

UVM Medical Center
111 Colchester Avenue
Burlington, VT 05401
Phone: (802) 847-3502
Fax: (802) 847-0384
PatientandFamilyAdvocacy@uvmhealth.org

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the Office of Patient and Family Advocacy is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at:

<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

Or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue SW
Room 509F, HHH Building
Washington, DC 20201
(800) 368-1019, (800) 537-7697(TTD)

Discrimination is Against the Law

NEPALI | नेपाली

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ ।
फोन गर्नुहोस् (802) 847-8899.

BOSNIAN | Bosanski

PAŽNJA: Ako govorite Bosanski, usluge pomoći jezika, bez naknade, na raspolaganju su vam. Poziv (802) 847-8899.

ARABIC | العربية

نإف تامدخ ؤدعاسملا ؤيوغلا رفاوتت كل ناجملاب. لصتا مقرب
ةطوholm: اذا تنك ثدحتت ركذا ؤغلا. (802) 847-8899.

SOMALI | Soomaali

DHEG: haddii aad ku hadashid Soomaali, adeegyada kaalmo luqadeed bilaash ayaa lagu helayo. Wac (802) 847-8899.

SPANISH | Español

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (802) 847-8899.

MANDARIN | 國語

注意：如果您说 中文，可免费获得语言援助服务。拨打
(802) 847-8899.

CANTONESE | 廣東話

請注意：如果你講 廣東話，語言協助服務係免費㗎，
如要幫助，請撥打熱線
(802) 847-8899.

VIETNAMESE | Tiếng Việt

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số (802) 847-8899.

FRENCH | Français

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le (802) 847-8899.

MAAY MAAY

DIGNIIN: hattii ada ka hadalaasa Maay Maay, adeegada gargaarka luugada, oo bilaash eh, yaa lakin helee ada. Han weer (802) 847-8899.

RUSSIAN | русском

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните (802) 847-8899.

SERBO CROATIAN | Srpsko-Hrvatski

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite (802) 847-8899.

THAI | ภาษาไทย

เรียน:

ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทาง
ภาษาได้ฟรี โทร (802) 847-8899.

TAGALOG

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa (802) 847-8899.

SWAHILI | Kiswahili

KUMBUKA: Ikiwa unazungumza Kiswahili, unaweza kupata huduma za lugha, bila malipo. Piga simu (802) 847-8899.

JAPANESE | 日本語

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。(802) 847-8899 まで、お電話にてご連絡ください。

BURMESE | ကရမ္မ

သတိပြုရန် - အကယ်၍ သင်သည် မြန်မာစကားကို ပြောပါက၊
ဘာသာစကား အကူအညီ၊ အခမဲ့၊ သင့်အတွက်
စီစဉ်ဆောင်ရွက်ပေးပါမည်။ ဖုန်းနံပါတ် (802) 847-8899 သို့ ခေါ်ဆိုပါ။

KIRUNDI | Ikirundi

ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona (802) 847-8899

KAREN | unD

ဟံသုဂ်ဟံသး- နမုာ်ကတိာ် ကညိ ကျိာ်အယိ. နမုာ် ကျိာ်အတိာ်မာစာလော
တလံာ်ဘျုးလံာ်စုာ် နိတမံးဘျုးသုနုာ်လိာ်. ကိး (802) 847-8899