



## Financial Assistance Program

802-847-8000, 800-639-2719

Fax: 802-847-7618

[CustomerService@UVMHealth.org](mailto: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 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

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 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](mailto:customerservice@uvmhealth.org). For help in completing the application, a Customer Service Representative or Financial Advocate is available M-F, 8:30am-4:30 pm at the UVMHC main campus, Patient Financial Services office 111 Colchester Ave, Burlington, VT 05401. Completed applications should be forwarded to the following address:

**The University of Vermont Medical Center  
Patient Financial Assistance Program  
Patient Access Dept.-IDX-22052  
111 Colchester Ave  
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 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](http://www.Nadaguides.com) and, if applicable, bank loan statement
- ☐ 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](mailto: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 Ave, 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 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](http://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...**

**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](http://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 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. 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 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 medical bills you cannot pay with The UVM 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.

## 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: <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

☐ Alice Hyde Medical Center ☐ Central Vermont Medical Center

☐ Champlain Valley Physicians Hospital ☐ 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.

<input type="checkbox"/> Vacation Home	<input type="checkbox"/> Second Home	<input type="checkbox"/> Land	<input type="checkbox"/> Not applicable	Value: \$
Location (address):				Mortgage Balance: \$
<input type="checkbox"/> Rental Property				<input type="checkbox"/> Not applicable
Location (address):				Mortgage Balance: \$

#### OTHER ASSETS AND LIABILITIES: Please check those that apply, or **check 'Not Applicable'**

<input type="checkbox"/> Boat	Value: \$	Loan Balance: \$	<input type="checkbox"/> Not applicable
<input type="checkbox"/> Camper	Value: \$	Loan Balance: \$	<input type="checkbox"/> Not applicable
<input type="checkbox"/> ATV / Snowmobile	Value: \$	Loan Balance: \$	<input type="checkbox"/> Not applicable
<input type="checkbox"/> All Other Debt		Loan Balance: \$	<input type="checkbox"/> Not applicable

Monthly Income From:	Person 1	Person 2	Documentation required for verification:
<b>Name of household member:</b>			
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
<b>Total:</b>	<b>\$</b>	<b>\$</b>	

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 PAP Specialist
<b>Total:</b>	<b>\$</b>	<b>\$</b>	

### 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

**2024 Income and Asset Guidelines**

To be eligible for financial assistance from The University of Vermont Medical Center, your assets and annual income should be at or below the 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 exceeds the guidelines, 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 **for laboratory services only, selective counties** 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 should be paid promptly.

FPLG	Less than 200%	201% - 250%	251% - 300%	301% - 350%	351% - 400%	Asset Limits
Financial Assistance Percentage	100%	85%	75%	65%	57%	
Household Size						
1 Person	\$30,120	\$37,650	\$45,180	\$52,710	\$60,240	\$50,000
2 Persons	\$40,880	\$51,100	\$61,320	\$71,540	\$81,760	\$50,000
3 Persons	\$51,640	\$64,550	\$77,460	\$90,370	\$103,280	\$50,000
4 Persons	\$62,400	\$78,000	\$93,600	\$109,200	\$124,800	\$50,000
5 Persons	\$73,160	\$91,450	\$109,740	\$128,030	\$146,320	\$50,000
6 Persons	\$83,920	\$104,900	\$125,880	\$146,860	\$167,840	\$50,000
7 Persons	\$94,680	\$118,350	\$142,020	\$165,690	\$189,360	\$50,000
8 Persons	\$105,440	\$131,800	\$158,160	\$184,520	\$210,880	\$50,000
9 Persons	\$116,200	\$145,250	\$174,300	\$203,350	\$232,400	\$50,000
10 Persons	\$126,960	\$158,700	\$190,440	\$222,180	\$253,920	\$50,000
11 Persons	\$137,720	\$172,150	\$206,580	\$241,010	\$275,440	\$50,000
12 Persons	\$148,480	\$185,600	\$222,720	\$259,840	\$296,960	\$50,000
13 Persons	\$159,240	\$199,050	\$238,860	\$278,670	\$318,480	\$50,000
14 Persons	\$170,000	\$212,500	\$255,000	\$297,500	\$340,000	\$50,000
15 Persons	\$180,760	\$225,950	\$271,140	\$316,330	\$361,520	\$50,000