

HEALTHCARE ASSURANCE PROGRAM

Dear Patient,

Central Vermont Medical Center is committed to providing essential health care to persons living within our service area. If payment of your medical bills creates a financial hardship for you, please complete this application and return it to us. We will determine if we can reduce or waive your medical bills for services provided at Central Vermont Hospital or our Central Vermont Physician Practices (see question #12 on the application). This program is available only for non-elective services and accounts that have not been placed with a collection agency.

Please answer every question. If the question does not apply to you, please indicate with N/A or None. All information you provide is confidential and is reviewed only by the staff processing your application. We will try to process the application as quickly as possible, and your assistance in providing required documentation of income will help us make a timely decision. We cannot process applications without income documentation.

Please send with your application any of the following documents that apply to your situation. If you are not able to obtain these documents, please contact our Financial Counselor.

- ◆ Your most recent Federal Income Tax return, including schedule C if self-employed
- ◆ If employed, copies of pay stubs for the last 3 months (or those available)
- ◆ If you are receiving Social Security benefits and/or pension payments, please send a copy of your check or deposit statement
- ◆ If you receive unemployment compensation, general assistance or food stamps, please send a copy of a recent document showing the amount of your benefit
- ◆ If you are not working or receiving benefits mentioned above, please include a written statement as to how you are supporting yourself

We can provide help in completing this application if needed. Please call our Financial Counselor at 371-4209 Monday through Friday from 8:00 a.m. – 4:30 p.m. if you need help or have questions about the application process or income verification.

If you do not wish to apply for this program, but cannot pay your outstanding balance in full, we can establish a monthly payment plan. We do not charge interest or fees for payment plans. Please call us at 371-5999 if you would like to make monthly payments.

Mail completed applications to: Central Vermont Medical Center
Healthcare Assurance Program
P. O. Box 547
Barre, Vt. 05641

**CENTRAL VERMONT MEDICAL CENTER
HEALTHCARE ASSURANCE PROGRAM**

P. O. Box 547, Barre, Vt. 05641
371-4209 or 371-5999

**Please answer all questions. If the question does not apply to you please indicate with
N/A or None.**

1. Patient's name _____ Age _____ Soc. Sec.# _____

2. Patient's address _____

3. Phone # _____ Cell Phone # _____

4. List **all** persons residing with the patient (including those not applying for assistance):

Name	Relationship to patient	Age	Name	Relationship to patient	Age
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

5. List current or last employment (include business or self-employment) for **all** household members:

Household Member Name	Name of Employer	Hire Date	Termination Date	Weekly Gross Pay
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

6. If you receive income from Social Security, disability, retirement, alimony, pensions, renters, business interests, food stamps, unemployment compensation, worker's compensation, child support, friends or relatives, or any other income, please list. If none, indicate "NONE."

Name of Person Receiving	Type of Income	Monthly Amount
_____	_____	_____
_____	_____	_____
_____	_____	_____

7. If you have no income, please attach an explanation of how you are meeting monthly expenses.

8. List assets such as checking or savings accounts in banks or credit unions, stocks, bonds, mutual funds, bank CD's, retirement accounts, annuities, trust funds or any other assets. If none indicate "NONE."

Name of Owner	Type of Asset and Name of Bank or other Institution	Current Balance
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you participating in a Healthcare Savings Account/Medical Savings Account Plan? No ___ Yes ___
If Yes, What is the current balance? _____

9. Do you own any real estate other than your primary residence? No ___ Yes ___
Street Address _____ Assessed Value _____
Description of Property _____ Mortgage Balance _____

10. Does the patient have Medical Insurance, Medicaid or VHAP? No ___ If yes, coverage and ID#(s) _____

If no insurance, have you lost coverage in the last 3 months? No ___ If yes, name of insurance _____
_____ Date coverage ended _____ Reason for Termination _____

11. Has the patient applied for Dr. Dynasaur, Medicaid, Catamount or VHAP? No ___ Yes ___ Date applied _____

12. Were you enrolled in the Veterans Administration Health Care System or have you received treatment in the VA facility within the past 24 months? No ___ Yes ___

13. Please check if you have bills from the following physician practices and wish to apply for assistance for them:

Assoc in Family Health ___ Barre Internal Medicine ___ Central Vermont Women's Health ___ Barre Pediatrics ___ Assoc in Pediatrics ___ Waterbury Medical ___ Family Psychiatry ___ Montpelier Integrative Family Health ___ Mtn View Urology ___ Central VT Primary Care ___ Central VT Rheumatology ___ Green Mtn Family Practice ___ Mad River Fam Practice ___ Mountain View Medical ___ Berlin Urology ___ Central VT Oncology ___ Central VT Cardiology ___ Central Vermont Neurology ___

14. Please list the following monthly expenses that apply to you:

<u>Monthly Expense</u>	<u>Monthly Payment</u>		<u>Monthly Payment</u>
Mortgage or Rent (circle which one)	_____	Telephone	_____
Property Taxes	_____	Water/sewer/trash	_____
Property Insurance	_____	Cable TV	_____
Car Payment	_____	Electricity	_____
Automobile Insurance	_____	Health Insurance	_____
Heating (oil, gas, wood)	_____	Life Insurance	_____
Child Care or Support	_____	Food/household items	_____
Medications/Prescriptions	_____	Gas/car maintenance	_____
Credit Cards	_____	Other Loan Pmts	_____
Medical Expenses (list Hosp or Dr.)	_____	Other	_____

Total Monthly Expenses _____

15. What monthly payment could you make toward your bill? _____

Please be sure you have included all verification of income including:

___ Most recent pay stub and/or copy of pension and/or social security income. If unemployed, send copy of unemployment compensation income. If applicable, copy of child support and/or workers comp income.

___ Most current tax return available, including schedule C if self-employed (it may be necessary to request a more current tax return when it becomes available, especially if you are self-employed.)

Please be sure you have answered every question and included all income documentation before signing and returning application to us. If this information is not included, we cannot process your application. Thank you.

I, the undersigned, certify that the information included in this application is true and complete to the best of my knowledge, and that any falsification will result in denial of my application for assistance. I authorize Central Vermont Medical Center to verify any of the above information. I specifically give permission to CVMC to obtain information from the Vermont Department of Social Welfare concerning the status of my application for any of their health insurance programs (Medicaid, VHAP, and Dr. Dynasaur).

Signature of Patient or Responsible Party

Date

Do not write below this line – for CVMC use only

Partial Approval _____ Approved _____ Denied _____

TGI _____ Faid GL _____ Authorized Signature _____ Date _____

Reviewed by _____ Date _____