As of March 2019

FINANCIAL ASSISTANCE

Get information on the UVM Medical Center's financial assistance programs and application process for uninsured patients and those with financial hardships.

Financial Aid at the UVM Medical Center

If you can't pay for medical services, that should not prevent you from getting the care you need. There are many options, including discounted and free care, for people who do not have insurance, who are not eligible for a government program, or who are insured but cannot pay for some reason. Please find more information below, and call 802-847-8000 with questions.

- Do you need help with medications, dental care, or glasses? Learn about our Health Assistance Program (/medcenter/Pages/Patients-and-Visitors/Patients/Assistance/Health-Assistance-Program.aspx).
- Learn about making Budget Payments (/medcenter/Pages/Patients-and-Visitors/Billing-Insurance-and-Registration/Budget-Payments.aspx)

For Patients Without Insurance

We offer discounts for patients without insurance. You may also qualify for further financial assistance. Please see below.

Discounts for medically necessary care

For patients who are not enrolled in a third-party insurance plan (view list of insurance plans (/medcenter/Pages/Patients-and-Visitors/Billing-Insurance-and-Registration/Insurance-Plans.aspx)), the UVM Medical Center offers a discount for medically necessary care. Below are some examples of services that are not eligible for a discount:

- Cosmetic procedures
- In vitro fertilization (IVF)
- Sterilization reversals

If single service costs more than $5,000, you may get a discount if you pay the full balance at the time of service. This is called a 'prompt pay discount

International discounts

- A 30% discount is available when paid in full at time of service.
- Patients with insurance are not eligible.
- International discounts cannot be combined with any other discount, package pricing or global fees.

If You Need Financial Assistance

To qualify:

- You must live in our service area. You must be a full-time Vermont resident or have lived more than six months in Vermont, or in the following New York counties: Clinton, Essex, Franklin, Washington, Hamilton, Warren or St. Lawrence. If you do not meet these requirements, you will only qualify for emergency care.
- Your medical service or procedure must be medically necessary. (For example, cosmetic procedures, IVF, and sterilization reversals are not eligible.)
- If you are eligible for government-sponsored programs, you are required to apply for Medicaid or coverage on the state health exchange before you will be considered for our Financial Assistance program.
- Your income must be below 400% of the Federal Poverty Level Guidelines (FPLG).
- Your assets must be below $50,000.
- If your income is above 400% of the FPLG, you can write a letter describing why you will have a hard time paying for your medical service. This will be reviewed by an appeals committee.
- If services are above 400% of the FPLG and are catastrophic in nature, coverage is available when the balance due exceeds 35% of the annual household income.

Budget Payments

If you can't pay your bill in full, we can help set up budget payments. This lets you make smaller payments over time, with no interest. The first step is to contact us:

- **For Hospital and Physician bills:** please contact Patient Financial Services at 1-802-847-8000.
- **For Anesthesia bills:** please contact PAR Management at 1-866-727-2040.

Below are general budget payment guidelines:

If your balance is:	Your budget payment is:
$0-50	$50
$51-600	$50
$601-1,000	$88

$1,001-1,800	$120
$1,801-3,000	$170
$3,001-4,500	$190
$4,501 and up	Please reach out to Patient Financial Services to determine an amount.

Vermont Federal Poverty Level Guidelines (FPLG)	<=200%	201-250%	251-300%	301-350%	351-400%
Grant Percentage	100%	85%	75%	65%	55%

How To Apply

To apply for the UVM Medical Center Financial Assistance Program, please complete the financial assistance application form (/medcenter/Documents/Patients-and-Visitors/Financial-Assistance-Program.pdf) and return it, along with the required documentation, to:

The University of Vermont Medical Center
Financial Assistant Program
111 Colchester Avenue
1 South Prospect Street Campus, 2nd Floor
Burlington, VT 05401

Application Form (/medcenter/Documents/Patients-and-Visitors/Financial-Assistance-Program.pdf)

Related Documents:

- Financial Assistance Policy (/medcenter/Documents/Patients-and-Visitors/Finanical-Assistance-Policy.pdf)
- Financial Assistance Policy Summary (/medcenter/Documents/Patients-and-Visitors/Financial-Assistance-Policy-Summary.pdf)

Get Help

If you have any questions about our Financial Assistance Program or your application status, contact customer service at 802-847-8000 or 800-639-2719 (toll-free) or via email at customerservice@uvmhealth.org (mailto:customerservice@uvmhealth.org).

If you are applying for **Vermont or New York Medicaid** and have questions: please contact our Financial Advocacy department at 802-847-1122.

Providers Who Offer Discounted Care

Not all providers are covered by our financial assistance policy, but the providers listed below do offer discounted care at the University of Vermont Medical Center. If your provider is not listed they are not covered under the financial assistance policy.

Here is how discounted care breaks down by the different types of bills you will receive:

- **Hospital bills**: All UVM Medical Center eligible services are covered under the financial assistance policy.
- **Provider bills**: To determine if your provider is covered under the financial assistance policy, please see the list below:

Print

Search:

Fullname	Organization/Practice	Qualifies for Financial Assistance
Abernathy, Karen MD	Adult Primary Care - Essex	Yes
Abernathy, Mac MD	Psychiatry - 1 South Prospect Street	Yes
Abnet, Kevin MD	Anesthesiology - Main Campus	Yes
Abujaish, Wasef MD	Bariatric Surgery - Williston	Yes
Adams, Julie PT	Rehabilitation Therapy Center - Fanny Allen Campus	Yes
Adeniyi, Aderonke MD	CVPH Cardiology	Yes
Ades, Philip MD	Cardiology - Tilley Drive	Yes
Ades, Steven MD	Hematology and Oncology	Yes
Adie, Tristin APRN	Adult Primary Care - South Burlington	Yes
Adler, Abigail MD	CVPH Hospitalist	Yes
Agrawal, Varun MD	Nephrology - Berlin	Yes
Aitken, Phil MD	Ophthalmology - Main Campus	Yes
Akin, Lee DDS	The University of Vermont Medical Center	No
Akselrod, Dmitriy MD	Radiology - Main Campus McClure	Yes
Albertson, Ryan APRN	Vermont Gynecology, PC	No

THE
University of Vermont
MEDICAL CENTER

Financial Assistance Program

(802) 847-8000, 800-639-2719
Fax: (802) 847-9332
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 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

THE University of Vermont MEDICAL CENTER

Financial Assistance Program

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. 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.

THE University of Vermont MEDICAL CENTER

Financial Assistance Program

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.

THE University of Vermont MEDICAL CENTER

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. 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.

☐ 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

THE University of Vermont MEDICAL CENTER

Financial Assistance Program

2018 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%	Asset Limits
Financial Assistance Percentage	100%	85%	75%	65%	55%	
Household Size*						
1 Person	$2,023.00	$2,529.00	$3,035.00	$3,541.00	$4,047.00	$50,000.00
2 Persons	$2,743.00	$3,429.00	$4,115.00	$4,801.00	$5,487.00	$50,000.00
3 Persons	$3,463.00	$4,329.00	$5,195.00	$6,601.00	$6,927.00	$50,000.00
4 Persons	$4,183.00	$5,229.00	$6,275.00	$7,321.00	$8,367.00	$50,000.00
5 Persons	$4,903.00	$6,129.00	$7,355.00	$8,581.00	$9,807.00	$50,000.00
6 Persons	$5,623.00	$7,029.00	$8,435.00	$9,841.00	$11,247.00	$50,000.00
7 Persons	$6,343.00	$7,929.00	$9,515.00	$11,101.00	$12,687.00	$50,000.00
8 Persons	$7,063.00	$8,829.00	$10,595.00	$12,361.00	$14,127.00	$50,000.00
9 Persons	$7,783.00	$9,729.00	$11,675.00	$13,621.00	$15,567.00	$50,000.00
10 Persons	$8,503.00	$10,629.00	$12,755.00	$14,881.00	$17,007.00	$50,000.00
11 Persons	$9,223.00	$11,529.00	$13,835.00	$16,141.00	$18,447.00	$50,000.00
12 Persons	$9,943.00	$12,429.00	$14,915.00	$17,401.00	$19,887.00	$50,000.00
13 Persons	$10,663.00	$13,329.00	$15,995.00	$18,661.00	$21,327.00	$50,000.00
14 Persons	$11,383.00	$14,229.00	$17,07500	$19,921.00	$22,767.00	$50,000.00
15 Persons	$12,103.00	$15,129.00	$18,155.00	$21,181.00	$24,207.00	$50,000.00

February 1, 2018

These guidelines are subject to change at any time.

Discrimination is Against the Law

THE University of Vermont MEDICAL CENTER

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

THE University of Vermont MEDICAL CENTER

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 ةدعاسملا ةيوغللا رفاوتت كل ناجملاب. لصتا مقرب (802) 847-8899،ةغللا ركذا تدحتت :اذإ تنك ثدحتت .ةظوحلم

SOMALI | Soomaali

DHEG: haddii aad ku hadashid Soomaali, adeegyada kaalmo luqadeed bilaash ayaa laguu 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。拔打 (802) 847-8899.

CANTONESE | 廣東話

请注意：如果你講 廣東話, 語言協助服務係免費嘅，如要帮助，请撥打熱線 (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:

ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี 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 | ြမန္မာစာ

သတိျပုရန္ - အကယ္၍ သင္သည္ ျမန္မာစကား ကို ေျပာပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊ သင့္အတြက္ စီစဥ္ေဆာင္ရြက္ေပးပါမည္။ ဖုန္းနံပါတ္ (802) 847-8899 သို့ ေခၚဆိုပါ။

KIRUNDI | Ikirundi

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

KAREN | unD

ဟ်သူဉ်ဟ်သး– နမ့်ကတိၤ ကညီ ကျိာ်ဒယိ. နမၤန့ၣ် ကျိာ်ဒတၢ်မၤစၢၤလၢ တလၢာ်ဘူဉ်လၢာ်စု၊ နီတမံၤဘဉ်သ့နှဉ်လီၤ. ကိး (802) 847-8899

As of Jan 2019

NMC
Northwestern Medical Center

Patient Financial Assistance

Applicability: Organizational	**Date Effective:** 10/2007
Department: Patient Financial Services	**Date Reviewed:** 10/2017
Supersedes: "Charity Free Care", "Eligibility Guidelines for Uncompensated Care"	**Date Last Revised:** 10/2017
Administration Approval: Stephanie Breault, Director of Finance Chris Hickey, Senior Vice President, Chief Financial Officer	

Purpose: To establish guidelines and the process for providing financial assistance to patients.

Policy Statement: At each patient registration/admission interaction, and in all oral communications regarding the amount due that occur during the Notification Period (defined below), NMC shall advise the patient of the availability of NMC's financial assistance program and where to obtain additional information about eligibility and how to apply. In addition, all points of check-in/registration areas for the hospital and physician practices shall have written materials regarding the financial assistance program and applications located in a conspicuous place easily viewable and accessible by patients, and such information shall be included in every patient admission packet. Relevant information about the hospital's financial assistance program shall also be available on the hospital's website and patient portal with an ability to download and print the financial assistance application without any special hardware or software.

Notice of financial assistance availability shall be noted on every patient billing statement sent out through NMC's contracted billing service. The billing service will direct individuals requesting financial assistance information to the hospital's website, or, at the patient's option, the billing service will mail a copy of the financial assistance application to the patient.
The Notification Period is defined as the period during which the hospital must notify an individual about its financial assistance policy in order to have been deemed to have made reasonable efforts to determine whether an individual is eligible for financial assistance. The Notification Period begins the first date that an episode of care is provided and ends the 120th day after NMC provides the first billing statement to the patient for the care. NMC must provide patients with written notice within 30 days of the end of the Notification period that the Notification Period is ending. Efforts are deemed reasonable if NMC notifies the patient about its financial assistance program as described above, and follows the requirements for incomplete and complete financial assistance applications described in the Review and Approval section below.

NMC
Northwestern Medical Center

NMC's financial assistance program shall be widely publicized within the community in a manner that will reasonably reach those who are most likely to require financial assistance. This shall generally be accomplished by information about the program being included in the local St. Albans Messenger newspaper and certain free publications in the greater Franklin and Grand-Isle counties periodically throughout the year. In addition, information about NMC's financial assistance program shall be displayed in a conspicuous public display at the Franklin-Grand Isle United Way office and the Vermont Department of Health St. Albans District office.

Background: The Patient Protection and Affordable Care Act of 2010 contains provisions that require 501(c)3 hospitals to comply with various patient billing and collection guidelines, including rules for offering financial assistance to patients. This policy shall become effective no more than 45 days after approved by the Board of Directors and shall not be retroactive.

Definitions: N/A

Procedure:

A. Eligibility Requirements

Financial assistance is provided on a sliding scale basis, based on the following eligibility criteria:

- Individual or family income – up to 300% of the federal poverty level. Employment status shall be considered when determining income levels. Prior income levels may not meet the established poverty level guidelines; however, recent unemployment should be considered as the current source of income.

- Individual or family net worth – up to $250,000, except for amounts owing NMC in excess of $100,000. When reviewing net worth, other financial obligations, such as high medical bills, should be considered. Patients with high net worth that would otherwise disqualify them for financial assistance may be considered for eligibility if they have, for example, uninsured catastrophic health care costs that would significantly reduce their net worth.

Financial assistance is available to all individuals for emergent care, and to individuals with a primary residence (live in for over 6 months a year) in Franklin or Grand Isle Counties for all services provided by the Hospital and Hospital owned physician practices, except elective services such as teeth extractions, voluntary sterilizations, cosmetic surgery and routine eye exams. Financial assistance is also available under the same guidelines as described within this paragraph for individuals obtaining services from NMC that are offered at NMC locations outside of Franklin or Grand Isle Counties.

Guidelines for determining eligibility for financial assistance shall be applied consistently. In determining a patient's eligibility for financial assistance, Patient Financial Services and its

Certified Financial Counselors will assist the patient (including referral to outside resources) in determining if he/she is eligible for government-sponsored programs, and to educate and assist them in understanding insurance coverages and available tax credits offered through Vermont Health Connect.

The Request for Financial Assistance Form (Free Care Application) shall be completed for all requests for financial assistance, and be submitted to Patient Financial Services. All requests for financial assistance must be signed by either the patient or authorized patient representative attesting that the information provided on the application is true and accurate.

1. **Verification of Information Provided**

Data used to determine eligibility for financial assistance should be verified to the extent practical in relation to the amount of financial assistance involved and the significance of an element of information in the overall determination. In all cases, the minimum verification shall include:

- Income, by reviewing sources such as a W-2, recent pay stub showing year-to-date totals, tax returns, unemployment statements, notices of social security and retirement benefits.

- An individual's net worth (excluding their primary household), by reviewing applicable supporting documentation (bank statements, investment statements, loan documents). It should be specified to the patient that assets could be considered as a possible source of payment.

Financial assistance of $5,000 or more may include documentation supporting other financial obligations, such as living expenses, child support, and other health care bills.

If a financial assistance application is received during the Application Period (as defined below) and deemed incomplete, a written notice to the patient/guarantor will be sent within 15 days of receipt of the incomplete application requesting the missing information be returned within 30 days of the date of the notice. Any extraordinary collection efforts, i.e., collection efforts by a collection agency, in progress at the time an incomplete application is received must be suspended. Such collections may be initiated or resumed if a completed application is not received after request for additional information is not received after 30 days of notification.

The required supporting documentation described above may be waived in lieu of information NMC obtains through use of technology tools as predictive measures of a patient's ability to pay and financial status.

2. Review and Approval

Financial assistance must be documented on the Request for Request for Financial Assistance Form and approved by the Patient Financial Services Representative for amounts up to $999, the Manager of Patient Financial Services for amounts of $1,000 to $9,999 and by either the Chief Executive Officer or Chief Financial Officer for any higher amounts. Documentation of receipt, review and approval of the Request for Financial Assistance shall be made on the Patient Request for Financial Assistance Processing Form – see attached. At the time a decision is made for the approval or denial of an account for financial assistance, a letter shall be sent to the patient or responsible party as notification of the decision made. The letter, which shall be sent within 15 days of receiving the Request for Financial Assistance Form, should be typewritten and should include the following information:

- Patient name
- Account number(s) for both hospital and physician accounts
- Current outstanding balance of the account(s)
- Dollar amount or number of days stay granted for financial assistance
- Any balance which will be due on the account (if only a portion of the account is covered by financial assistance)
- Detail of arrangements to pay for any remaining balance on the account after financial assistance is provided
- Appeal process if request for financial assistance was denied

Upon approval of a financial assistance request, NMC shall:

- If any amount is due from patient, provide a billing statement to the patient showing the amount due, how the AGB (see definition in the Charge Limitation section below) was determined, and how the amount due was arrived at;
- Refund any payments made by the patient in excess of amounts approved for financial assistance; and

Approval of financial assistance will be denied if Medicaid or other health and welfare eligibility application is refused by patient if NMC reasonably believes that the patient could qualify. In addition, the patient is expected to cooperate with NMC in reviewing affordable insurance coverage options offered through Vermont Health Connect. If the patient chooses not to purchase insurance coverage through the Vermont Health Connect and does not quality for VT Medicaid, then the patient will be required to submit a Financial Assistance application, along with a letter explaining why they have chosen not to purchase insurance coverage. The information contained in the letter will be used in the process of evaluating the patient for NMC financial assistance. Financial assistance will also be denied if the patient does not

provide additional information (if required). Assignment to Hospital of all insurance payments, including liability settlements, is required, up to the amount of gross charges on a patient's bill.

Denials of financial assistance may be appealed. Appeals must include an appeal letter from the patient or party with financial responsibility requesting reevaluation (Free Care Appeal Form). The appeal must also include any supporting documents that may prove inability to pay that were not part of the initial consideration. Appeals will be referred to and reviewed by the Manager of Patient Financial Services within thirty (30) days of being received. If the Manager of Patient Financial Services feels additional input is needed in making a determination, the Chief Financial Officer will be asked to review and assist with the determination.

If subsequent to review and determination of financial assistance it is found that the information relied on was in error, the following shall occur:

- If the corrected information in a prior denial of financial assistance now qualifies the patient for financial assistance, the patient will be notified that they are now eligible for financial assistance and the account(s) will be processed as described above.

- If the corrected information in a prior granting of financial assistance now disqualifies the patient for financial assistance, the patient will be notified that they are not eligible for financial assistance and payment is expected on their account(s).

The completed Financial Assistance Processing Form and Request for Financial Assistance will be scanned into the patient's accounts in Meditech or Medent as appropriate.

Notwithstanding the above, NMC must accept and process a financial assistance application for a period up to 240 days after NMC provides the first billing statement to the patient. (defined as the Application Period). NMC may initiate or resume extraordinary collection actions, i.e., transfer account to a collection agency, against an individual who has submitted an incomplete financial assistance application and who has not provided the missing information necessary to complete the application any earlier than the later of:

- 30 days after NMC provides written notice that the additional information is required, or
- The last day of the Application Period

Key timeframes required to be provided under this policy are flowcharted in Attachment A to this policy.

3. **Accounting for and Tracking Financial Assistance Data**

Approved financial assistance shall be classified and recorded as charity care, because, by definition, charity care is "demonstrated inability to pay". The amount of charity care provided will be reported separately in the monthly financial statements.

Finance shall calculate the cost associated with the services approved for financial assistance for disclosure in the annual financial statements.

4. **Frequency of Re-Evaluation of Eligibility**

Once a patient has been approved for financial assistance, as well as a discount based on poverty level and net assets as described in a separate Discounts for Medical Services policy, the patient will be deemed to have approval for services rendered by the hospital for one year subsequent to approval, except as follows:

- There is a change in financial status as described below. After one year, the patient will be required to re-apply for financial assistance, and the appropriate verifications of information will need to be made.

- In NMC's reasonable estimation, patient can afford to purchase insurance coverage through Vermont Health Connect and the period for which such coverage can be obtained is in less than six months from the time financial assistance is granted by NMC.

If a patient is granted financial assistance on a portion of their bill, and the patient subsequently does not pay their remaining portion of the bill, NMC will not reverse the amount of financial assistance granted.

5. **Changes in Patient Financial Status**

Patients may have unexpected changes to their ability to pay that occur after the time service is rendered and after either a payment plan or financial assistance has been granted. If a patient agreed to a payment plan (see separate Patient Payment Plans policy) that was reasonable in relation to his or her circumstances at the time, but the patient subsequently lost his or her job or had some other financial hardship occur and became unable to pay under the plan, the patient may apply for financial assistance under the guidelines of this policy.

Alternatively, if a patient who was granted financial assistance but subsequently experiences a positive change to his or her ability to pay for the services rendered, the hospital may bill the patient for the services rendered and advise the patient of their change in status.

6. **Charge Limitation**

Individuals who qualify for financial assistance will not be charged more than the Average Generally Billed (AGB) amount (effectively the amounts NMC collects from insurance companies and Medicare). This amount will be determined by doing a yearly look-back of payment percentages from commercial payers and Medicare (including copayments and deductibles paid by patients). Separate payment percentages will be calculated to develop separate AGB amounts for inpatient, outpatient, and physician practice/clinic services. AGB amounts shall be calculated by the 45th day after September 30th each year for the 12-month period ended September 30th. The billing statement to a patient may state the standard hospital gross charge, but must show a write-off to get to the AGB. The difference between the hospital's standard gross charge and the AGB amounts will be accounted for as a charity care write-off.

This policy is not required to be approved by the Board each year for updates to the AGB.

7. **Discounts**

Patients who do not qualify for financial assistance as provided in this policy may receive a discount as described in the Discounts for Medical Services policy.

8. **Medicaid Coverage**

Medicaid copays not paid at the time of service will be billed to the patient. If unable to collect the copays by the end of the Application Period, the copays will be written off as a charity write-off.

Patients who have Medicaid coverage and have balances due for service dates up to twelve months prior to the effective date of their coverage, will be granted 100% financial assistance on such balances without further review or documentation from the patient.

9. NOTCH Collaboration

NMC is working in collaboration with Northern Tier Center for Health (NOTCH), our local FQHC, in qualifying their patients for financial assistance for services performed at NMC. NOTCH patients approved for discounted or uncompensated services through NOTCH are also eligible for the same at NMC because Notch's guidelines are stricter than NMC's. NOTCH will forward the patient's applications with supporting documentation to NMC. If upon review, it appears that the patient would be eligible for Medicaid coverage, the patient will be required to apply for Medicaid before any financial assistance will be applied to uninsured balances.

10. Other

Generally the determination that a patient stay qualifies for financial assistance will be made upon pre-admission, admission or as soon as possible thereafter. A Patient Financial Counselor is available near the front entrance of the hospital to assist patients with settlement of their accounts including applications for financial assistance, government sponsored programs and referral to outside resources. However, in some cases qualification for financial assistance may be made after rendering services and in some circumstances even after rendering of the bill. Collection efforts, including the use of a collection agency, are part of the information collection process and can appropriately result in identification of eligibility for financial assistance.

Services rendered at NMC by radiologists and anesthesiologists (including certified nurse anesthetists) are from separate entities that are not affiliated with NMC and therefore are not subject to NMC's financial assistance policies.

For questions related to this policy and all forms please contact our Financial Counselor, Bryan Kiernan at address below

Northwestern Medical Center
133 Fairfield Street
St. Albans, VT 05478
802-524-1006
bkiernan@nmcinc.org

Note Well: N/A

Monitoring Plan: N/A

Related Policies:
Patient Payment Plans
Guidelines for Patient Discounts
Discount for Medical Services

Northwestern Medical Center List of Providers

References: Health Care Financial Management Association Principles and Practices Board Statement 15, "Valuation and Financial Statement Presentation of Charity Care and Bad Debts.

American Hospital Association Hospital Billing and Collection Practices Statement of Principles and Guidelines May 5, 2012

Patient Protection and Affordable Care Act

IRS Notice 2014-2 issued on December 30, 2013

IRS CFR Parts 1, 53, and 602 (issued December 29, 2014)

Also refer to the policy entitled "Billing and Collection Practices"

Reviewers:

A. **Key Stakeholders:** Fred O'Neil – Manager, Patient Access
B. **Committees:** None
C. **Key Process Owner:** Megan Branon Smith- Manager, Patient Financial Services

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Keywords - Not Part of Policy: Patient Assistance, Financial Assistance, Charity Care, Free Care

Dear Patient:

Thank you for choosing Northwestern Medical Center for your health care needs. If payment of your medical bills would create a financial hardship for you, we will work with you to apply for financial assistance. All other potential payment sources will need to be explored first, such as insurance, Government programs, etc. We may require that you apply for Medicaid.

Please answer all questions on the application completely—indicate "zero" or "does not apply" where appropriate. Applications that are incomplete or do not have appropriate proof of income will be returned requesting additional information.
The following proof of income is requested:

- Most recently completed federal tax return
- Copies of Social Security checks or documentation from Social Security of your benefits
- A bank statement showing direct deposits of retirement or Social Security benefits.
- Proof of Child Support paid or received

We will notify you of our decision within 15 days of receipt of a complete application. If you have any further questions regarding this process, please contact me at
(802) 524-1006.

***All personal information submitted will be held in strictest confidence.**

Sincerely,

Bryan Kiernan
Financial Counselor
Northwestern Medical Center
133 Fairfield Street
St Albans, VT 05478

NORTHWESTERN MEDICAL CENTER
REQUEST FOR FINANCIAL ASSISTANCE

PATIENT INFORMATION

Name _____

Mailing Address _____

Daytime Phone _____

GUARANTOR/SPOUSE

Name _____

Mailing Address (if different than above) _____

Daytime Phone _____

Employer _____

Social Security Number _____

NAME AND AGES OF PEOPLE PATIENT/GUARANTOR/SPOUSE ARE FINANCIALLY RESPONSIBLE FOR:

Name _____ Age _____

Name _____ Age _____

Name _____ Age _____

Name _____ Age _____

PLEASE COMPLETE THE ATTACHED FINANCIAL DISCLOSURE WORKSHEETS AND ENCLOSE THE SUPPORTING DOCUMENTATION DESCRIBED IN THE ATTACHED LETTER

I affirm that all information provided on this application is accurate to the best of my knowledge. I authorize Northwestern Medical Center to verify employment, and all financial information provided herein to determine eligibility for financial assistance.

Signature of Patient or Guarantor _____

Print Name of Person Completing this Application _____

Date _____

Please return to Bryan Kiernan

MONTHLY HOUSEHOLD NET INCOME

Income

Gross salaries/wages/tips	$ _____
Social security payments received	_____
Pension or retirement payments received	_____
Interest income	_____
Dividend income	_____
Unemployment/workers' compensation payments received	_____
Rental income	_____
Child support/alimony payments received	_____
Other (describe):	
_____	_____
_____	_____
Total Monthly Income	$ _____

Expenses

Mortgage/rent	$ _____
Property taxes	_____
Auto loans	_____
Credit card payments	_____
Utilities	_____
Child support/alimony	_____
Insurance--auto, home, health	_____
Medical expenses	_____
Other living expenses--telephone, heat,food,gas,water,sewer,rubbish	_____
Other (describe):	
_____	_____
_____	_____
Total Monthly Expenses	$ _____

TOTAL MONTHLY HOUSEHOLD NET INCOME
(monthly income minus monthly expenses) $ _____

PATIENT NAME _____

NET WORTH

Assets

Balance in checking accounts	$ _____
Balance in savings accounts	_____
CDs	_____
Stocks	_____
IRAs, 401ks, and other retirement funds	_____
Market value of real estate (other than primary residence)	_____
Market value of autos	_____
Other assets (describe):	
_____	_____
_____	_____
_____	_____
Total Assets	$ _____

Liabilities

Outstanding balance on credit cards	$ _____
Outstanding balance on auto loans	_____
Outstanding balance on real estate loans (excluding primary residence)	_____
Other debt (describe):	
_____	_____
_____	_____
_____	_____
Total Liabilities	$ _____
NET WORTH (total assets minus total liabilities)	$ _____