Copley Hospital Patient Financial Services
528 Washington Hwy, Morrisville, VT 05661
Phone: (802) 888-8338 Fax: (802) 888-8203

FINANCIAL ASSISTANCE APPLICATION

Dear Applicant,

Thank you for choosing Copley Hospital. We are committed to providing quality health care to everyone, regardless of their ability to pay. If payment of your medical bills creates a financial hardship for you, you may be eligible for assistance under Copley Hospital's Financial Assistance Program.

The following criteria must be met to be eligible under Copley Hospital's Financial Assistance Program:

- You must be a full-time resident of Vermont, or must reside in Vermont for more than the last consecutive 6 months. Proof of residency may be requested of the applicant during the application screening process. Applicants that do not meet this residency requirement may be considered for financial assistance for emergency medical care only.
- Your household income and assets, or resources, must be within our eligibility guidelines. Household income must be at or below 400% of the Federal Poverty level Guidelines. Household assets, or resources, must be below 400% of the Federal Poverty level Guidelines.
- Medical services provided to you must meet certain criteria. The following services are excluded from the Financial Assistance Program:
    - Services not deemed medically necessary essential health care services. Determination of medical necessity may require the input from the attending physician to take into account all the relevant facts and circumstances of your health care needs.
    - Services that have been denied by insurance due to your non-compliance with the requirements of your insurance plan.
    - Services reimbursed directly to you by an insurance carrier or another third party.

If you believe you may be eligible for Copley Financial Assistance Program, please fill out the enclosed application by answering all of the questions completely. Please be sure to include all of the required supporting documentation and sign the certification statement at the end of the application. The application and all of your supporting documentation are kept confidential. For your convenience, a documentation checklist is provided on the next page.

During the application screening process, we will work with you to identify other potential sources of payment for your medical bills. If we identify a potential alternative payment source through Vermont's Health Insurance Exchange (Vermont Health Connect), you will be asked to cooperate with us to determine eligibility for that program. Failure to cooperate with applying for alternative sources of payment for your medical bills will be considered a voluntary withdrawal of the application for assistance from Copley Hospital.

If you have any questions about the Financial Assistance Program, the application process, or would like assistance with completing the application, please feel free to contact me directly at (802) 888-8336 or agriggs@chsi.org. I would be pleased to have the opportunity to help you.

Sincerely,

Angela Griggs
Patient Financial Counselor, CAC

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FINANCIAL ASSISTANCE APPLICATION DOCUMENTATION CHECKLIST

In order to process your application, you must fill out the application by answering all of the questions completely and including all of the required supporting documentation. For your convenience, following is a checklist that you can use to be sure that we receive all of the information needed to quickly process your application.

N/A	Yes	
☐	☐	Most recently filed federal income tax return and W-2's, including all forms and schedules related to each member of the household and any partnership, self-employment, or rental income.
☐	☐	Most recent bank statement(s) for all checking and savings accounts
☐	☐	Most recent bank/broker statement(s) for all investment accounts, annuity accounts, trusts, CDs, etc.
☐	☐	Most recent pay stub from each place of employment during the year, with year-to-date earnings. If year-to-date earnings are unavailable, submit your last three most recent pay stubs from each place of employment.
☐	☐	If you received unemployment benefits during year, submit unemployment statement(s) or other documentation such as check stubs or bank statement.
☐	☐	If you own a business, submit a signed statement from you estimating the amount of net income you project from your business for this year. You may use the federal income tax forms as a template to estimate your business net income, or call our Financial Counselor to request a template that you can use.
☐	☐	Copy of Social Security Statement, or a copy of your bank statement showing deposit
☐	☐	Letter of determination for 3SquaresVT (Food Stamps), Fuel Assistance, and/or General Assistance
☐	☐	If you receive alimony or child support payments, provide a copy of cancelled check, evidence of garnishment in paycheck, or bank statement showing deposit.
☐	☐	Review that the Application form is filled out completely.
☐	☐	Sign and date application.

COPLEY HOSPITAL

FINANCIAL ASSISTANCE APPLICATION

PRIMARY APPLICANT (Parent if patient is a minor)
Last Name_____ First_____ Middle_____

Date of Birth _____ SSN_____ Daytime Phone/Cell _____

Mailing Address_____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Employment Status: ☐ Student ☐ Retired ☐ Disabled ☐ Unemployed ☐ Self-Employed ☐ Employed

If employed, list employer(s) _____ How long employed? _____

SPOUSE or CO-APPLICANT (Must be member of household)

Last Name_____ First_____ Middle_____

Date of Birth _____ SSN_____ Daytime Phone/Cell _____

Employment Status: ☐ Student ☐ Retired ☐ Disabled ☐ Unemployed ☐ Self-Employed ☐ Employed

If employed, list employer(s) _____ How long employed? _____

DEPENDENTS (Must be claimed on Federal Tax Returns)

Last name_____ First_____ Middle___ DOB _____ SSN_____

Last name_____ First_____ Middle___ DOB _____ SSN _____

Last name_____ First_____ Middle___ DOB _____ SSN_____

OTHER INFORMATION

Are you covered under any health insurance policy? ☐ No ☐ Yes Is Co-Applicant: ☐ No ☐ Yes
If yes, list insurance(s): Primary: _____ Secondary: _____

Do you and/or your dependents have an application pending for insurance on the Health Exchange, Medicaid, or Dr. Dynasaur? ☐ No ☐ Yes: Date applied _____

Note: If you meet certain criteria, we may require that you apply for State Aid programs in order to process your application for financial assistance

Are you seeking financial assistance resulting from an accident or injury related to any of the following: ☐ Work Related ☐ Motor Vehicle ☐ Other Liability ☐ None of these

Did you file and/or are you required to file a Federal Tax return? ☐ Yes (provide copy of most recent return)
☐ No: Why? _____

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

Do you prefer to be contacted by e-mail? ☐ No ☐ Yes: E-Mail _____

COPLEY HOSPITAL

FINANCIAL ASSISTANCE APPLICATION

HOUSEHOLD INCOME & ASSETS

Monthly Income From:	**Applicant 1**	**Applicant 2**	**Documentation Required:**
Name:	_____	_____	
Gross Wages	$ _____	$ _____	Most recent pay stub
Self Employment Income	$ _____	$ _____	Tax Return / Estimated Profit & Loss
Rental Income	$ _____	$ _____	Tax Return / Estimated Profit & Loss
Unemployment	$ _____	$ _____	Check stub, bank statement, online, etc
Workers Compensation	$ _____	$ _____	Check stub, bank statement, online, etc
3SquaresVT (food stamps)	$ _____	$ _____	Award letter, check stub, bank stmt
Public assistance	$ _____	$ _____	Award letter, check stub, bank stmt
Disability	$ _____	$ _____	Check stub, bank statement, online, etc
Child support or alimony	$ _____	$ _____	Check, garnishment, bank stmt, etc
Social Security	$ _____	$ _____	Award letter, check stub, bank stmt
Pension/Retirement Income	$ _____	$ _____	Check stub, bank statement, online, etc
Dividend Income	$ _____	$ _____	Recent investment statement
Other: _____	$ _____	$ _____	Specify other income
Total:	**$ _____**	**$ _____**	

Cash & Investments:	**Applicant 1**	**Applicant 2**	**Documentation Required:**
Name:	_____	_____	
Checking account(s)	$ _____	$ _____	Bank statement
Savings account(s)	$ _____	$ _____	Bank statement
Investment account(s)	$ _____	$ _____	Investment/broker statement
Trust Account	$ _____	$ _____	Investment/broker statement
Annuities	$ _____	$ _____	Investment/broker statement
Other: _____	$ _____	$ _____	Specify
Total:	**$ _____**	**$ _____**	

PLEASE READ CAREFULLY AND SIGN BELOW

I, the undersigned, certify that all information provided in this application is true and complete to best of my knowledge. I authorize Copley Hospital to verify any of the information provided and any falsification will result in the denial of my application for assistance. If I receive payment of any kind for the medical services covered by this financial assistance application, I agree to repay the financial assistance award up to the lesser of the payment received or assistance awarded. All information provided will remain confidential.

Signature of Applicant _____ Date _____
(Parent of minor)

Signature of Co-Applicant _____ Date _____