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

FINANCIAL ASSISTANCE APPLICATION LETTER

Dear Applicant,

Thank you for choosing Copley Hospital. We are committed to providing quality health care to everyone, regardless of 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 resident of Vermont. A Vermont resident means an individual, regardless of citizenship and including undocumented immigrants, who resides in Vermont, is employed by a Vermont employer to deliver services for the employer in this State in the normal course of the employee's employment, or attends school in Vermont, or combination of these. The term includes an individual who is living in Vermont at the time that services are received but who lacks stable permanent housing. Applicants that do not meet this residency requirement may be considered for financial assistance for emergency medical care only.
- Your household income and liquid assets (or resources) must be within our eligibility guidelines. Household income must be at or below 600% of the Federal Poverty Levels (FPL). Household liquid assets (or resources) must be below 400% of the FPL.
- Medical services provided to you must meet certain criteria. The following services are excluded from the Financial Assistance Program:
    - Services not deemed medically necessary health care services. Determination of medical necessity may require the input from the attending physician to consider all relevant facts and circumstances of your health care needs.
    - Services that have been denied by insurance due to non-compliance with the requirements of your insurance plan.
    - Services reimbursed directly to you by an insurance carrier or other third party.

If you believe you may be eligible for Copley Hospital's Financial Assistance Program, please fill out the enclosed application by answering all questions completely. Please be sure to include what you can of the requested supporting documentation and sign the certification statement at the end of the application. The application and all 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.

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

To process your application, you must answer all questions completely and include any supporting documentation possible. For your convenience, the following checklist can be used to help ensure we receive all your information and can process your application quickly and efficiently.

N/A	Yes	
		Proof of income:
☐	☐	Please provide your most recently filed federal income tax return, including all forms (for example W-2s) and schedules related to each member of the household and including any business or rental income.
		Alternatively, or in addition to your tax return, you may provide:
☐	☐	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 most recent pay stubs from each place of employment for the past 30 days.
☐	☐	Most recent statements from Social Security Administration and all banks or brokers for all investment accounts, annuity accounts, trusts, CDs, etc.
☐	☐	If you received unemployment benefits during year, submit unemployment statements or other documentation such as check stubs or bank statements.
☐	☐	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.
☐	☐	If you receive alimony from a settlement executed before 2019, copies of cancelled checks, or bank statements showing deposits.
		Proof of liquid assets (do NOT include your primary home, car or retirement accounts):
☐	☐	Support for liquid assets not provided above such as secondary property tax bill.
		Complete the application:
☐	☐	Review the application to ensure it 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 _____ How long employed? _____

CO-APPLICANT (Spouse, domestic partner or other member of the household)

Last Name_____ First_____ Middle_____

Date of Birth _____ SSN_____ Daytime Phone/Cell _____

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

If employed, list employers _____ How long employed? _____

DEPENDENTS FROM YOUR TAX RETURN (If you do not file taxes, list the people who would be your tax dependents if you filed.)

Last name_____ First_____ Middle___ DOB _____ SSN_____

Last name_____ First_____ Middle___ DOB _____ SSN _____

Last name_____ First_____ Middle___ DOB _____ SSN_____

OTHER INFORMATION

Are you or the co-applicant covered under any health insurance policy? ☐ No ☐ Yes
If yes, list insurers: Primary: _____ Secondary: _____

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

You are seeking financial assistance for medical bills resulting from an accident or injury related to:
☐ Employment ☐ Motor vehicle ☐ Other liability ☐ None of these

Did you file a federal tax return? ☐ Yes (provide copy of most recent return)
☐ No: (provide alternative income support)

Do you live in, work in, or go to school in Vermont? ☐ Yes ☐ No

If you prefer to be contacted by e-mail, please provide your e-mail address:

_____

COPLEY HOSPITAL

FINANCIAL ASSISTANCE APPLICATION

HOUSEHOLD INCOME & LIQUID ASSETS

	Primary Applicant	Co-applicant	From income tax return or these alternative documents:
Name:			
Monthly Household Income From:			
Gross wages	$	$	Most recent pay stub
Self-employment income	$	$	Estimated profit and loss
Rental income	$	$	Estimated profit and loss
Unemployment	$	$	Check stub, bank statement, online, etc.
Disability	$	$	Check stub, bank statement, online, etc.
Alimony (executed pre-2019)	$	$	Check stub, bank statement, online, etc.
Retirement income	$	$	Check stub, bank statement, online, etc.
Investment income	$	$	Recent investment statement
Social Security Retirement and Social Security Disability income	$	$	Award letter, check stub, bank stmt. Do **NOT** send Supplemental Security income
Other: _____	$	$	Specify other income
Total:	**$**	**$**	
Liquid Assets (cash and investments):			
Checking accounts	$	$	Bank statements
Savings accounts	$	$	Bank statements
Certificates of deposit, stocks, bonds and/or mutual funds accounts	$	$	Investment/broker statements Do **NOT** include retirement accounts or pensions
Trust accounts if liquid	$	$	Investment/broker statements
Annuities if liquid	$	$	Investment/broker statements
Other liquid assets: _____	$	$	Specify other liquid assets
Total:	**$**	**$**	

PLEASE READ CAREFULLY AND SIGN BELOW

I, the undersigned, certify that all information provided in this application is true and complete to the best of my knowledge. I understand any misrepresentation or falsification could 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 Primary Applicant _____ Date _____
(Parent of minor)