SOUTHWESTERN VERMONT MEDICAL CENTER

FINANCIAL ASSISTANCE / FREE CARE FORM

Southwestern Vermont Medical Center is committed to its community by making available free care to all its patients living within its service area. The determination in establishing free care is based on doubling the most recent published poverty guidelines as set forth by the Federal Government. All requests for free care should be made either prior, during or within sixty (60) days following services. Patients should be full time residents of our service area for at least six months to qualify.

Please complete the attached form, sign it and return all the necessary information needed. All applications must have proof of income attached. The hospital does reserve the right to request a copy of the Medicaid Denial of Assistance if proof of income appears to be within the Medicaid Eligibility Guidelines or if income can not be verified. Your application will be reviewed to determine eligibility and you will be notified of our determination in a timely manner. All applications for free care without the necessary documentation for support will be returned to the patient. **Please include all applicable documentation from the list below:**

1. **Copy of prior year Federal Tax Return**
2. **Copy of prior year State Tax Return**
3. **Copy of Business Tax Return (If applicable)**
4. **Copies of 2 most recent pay stubs or written verification from employer**
5. **2 Months of bank statements including checking, savings and money market**
6. **Copy of Social Security income statement**
7. **Copy of pension benefit statement**
8. **Copy of unemployment benefit statement**

Effective 1/1/2016, the income requirements are:

Family Size	< 225% FPL 100% Discount	300%FPL 75% Discount	400%FPL 65% Discount
1	$26,730	$35,640	$47,520
2	$36,045	$48,060	$64,080
3	$45,360	$60,480	$80,640
4	$54,675	$72,900	$97,200
5	$63,990	$85,320	$113,760
6	$73,305	$97,740	$130,320
7	$82,643	$110,190	$146,920
8	$92,003	$122,670	$163,560
Over 8	Add $9,360 per person	Add $12,480 per person	Add $16,640 per person

Please return application and proof of income to: **SVMC**
100 Hospital Drive, Box 52
Bennington, VT 05201

You can either bring in our forms in person or mail them to a Patient Financial Advisor. Should you require any help in completing these forms, please either call (802) 447-4502 or come see us in person. A Patient Financial Advisor will be glad to assist you.

Request for Determination of Eligibility for Uncompensated Services

I hereby request that Southwestern Vermont Medical Center make a written determination of my eligibility for uncompensated services at Southwestern Vermont Medical Center. I understand that the information that I submit concerning my annual income and family size is subject to verification and if it is determined to be false, such a determination will result in a denial of providing services as uncompensated services and that I will be liable for charges of such services provided.

Name: _____ Date of Birth:_____

Address: _____

Phone Number (Home):_____ Work:_____

Employer:_____ Occupation: _____

Spouse Name: _____ Date of Birth:_____

Spouse Employer: _____ Occupation: _____

Family Size: _____

Please list dependents:

Name	Relationship	Date of Birth

Monthly Household Income (Gross Income)

	Self	Spouse
Wages……	_____	_____
Farm or Self-Employment	_____	_____
Public Assistance…….	_____	_____
Social Security…….	_____	_____
Unemployment……...	_____	_____
Workman's Compensation...	_____	_____
Alimony……	_____	_____
Child Support ……..……	_____	_____
Pensions……..	_____	_____
Income from Dividends…..	_____	_____
Interest, Rent, Etc……...	_____	_____

Types of Services Required/Received: _____

Have you applied for state health insurance ☐Yes ☐No.?

If yes, what is the status of the application? _____

Did you file previous year taxes ☐Yes ☐No?

If No, please indicate why you did not file taxes:

_____

I affirm that the following information is true and correct to the best of my knowledge:

Signature: _____ Date: _____