



NORTH COUNTRY HOSPITAL

Get help paying for health care.

We have a financial assistance program to help you afford the care you need.

What is the financial assistance program?

We give free and low-cost care to people at North Country Hospital. It is for people who are uninsured and people who have insurance with out-of-pocket costs. It can be used for ongoing care and emergencies. The care must be medically necessary for your health.

Who can get financial assistance?

To qualify:

- **You must be a “Vermont resident”** – this includes students, people who are employed in Vermont, undocumented immigrants, people who live in Vermont but do not have housing (ex: homeless), etc.
- **Your income must be less than the limit.** There are different income limits for free and low-cost care. See the charts.
- **Your “liquid” resources must be less than the limit.** These are cash, checking and savings accounts, etc. (Your primary home, car, and retirement accounts will not count against you.)

Income limits

Find your household size and income on the charts below. For most people, your household size will be the people listed on your taxes. If you make too much money for free care, you might qualify for low-cost care.

Free care

You could get **free care (pay \$0)** if your household income is below **250% of the Federal Poverty Level**. In 2024, your income would need to be less than:

| Household Size | Maximum Income |
|----------------|----------------|
| 1 person | \$37,650 |
| 2 people | \$51,100 |
| 3 people | \$64,550 |
| 4 people | \$78,000 |
| 5 people | \$91,450 |
| 6 people | \$104,900 |
| 7 people | \$118,350 |
| 8 people | \$131,800 |

Low-cost care

You could get a **40% discount** if your household income is below **400% of the Federal Poverty Level**. In 2024, your income would need to be in this range for your household size:

| Household Size | Income Range |
|----------------|-----------------------|
| 1 person | \$37,651 – \$60,240 |
| 2 people | \$51,101 – \$81,760 |
| 3 people | \$64,551 – \$103,280 |
| 4 people | \$78,001 – \$124,800 |
| 5 people | \$91,451 – \$146,320 |
| 6 people | \$104,901 - \$167,840 |
| 7 people | \$118,351 - \$189,360 |
| 8 people | \$131,801 - \$210,880 |

*****More information on next page*****

Catastrophic care

Ask us about catastrophic care if you owe the hospital a lot of money, but your income is too high to qualify for free or low-cost care. It is for people with income that is less than 600% of the Federal Poverty Level and who owe more than 20% of their yearly income to the hospital for out-of-pocket costs. We can help you figure out if this could help.

How to apply

You can apply before or after you get services. If you apply after you get services, you must do this within 365 days, (one-year) of getting the first bill.

Follow these steps:

1. Get a free application.

- In-person: 189 Prouty Drive Newport, Vermont.
- Online: <https://northcountryhospital.org/>.
- By mail: Call 802-334-3210 ext. 4204 and ask us to mail you a copy for free.

2. Fill out the application.

3. Give or send us your finished application with requesting documents.

- **“Income”** Provide at least one: paystubs, most recent state, or federal income tax return, or in lieu of submitting a tax return, documentation of public assistance, or other documentation accepted as valid documentation of income by the Vermont Department of Health Access, such as a bank statement, profit and loss statement, letter from an employer, or self-attestation in extenuating circumstances in which no other documentation is available.
- **“Liquid asset”** proof of asset that is cash or can be easily converted to cash such as cash, checking and savings accounts, money markets, stocks, bonds, and certificates of deposit.
- Drop it off at: 189 Prouty Drive, Newport, Vermont
- Mail it to: North Country Hospital
Attention: Financial Navigator
189 Prouty Drive
Newport, VT 05855

What happens next?

You will get a letter from us in the next 30 days. It will say if you are approved, denied, or need to send more information. If it has been more than 30

days and you do not get a letter, please call us: 802-334-3210 ext. 4204.

How to get help

You can get free help with the application.

- **Visit our financial counseling office:** at 189 Prouty Drive or 186 Medical Village Dr, Newport, VT.
- **Call:** 802-334-3210 ext. 4204.
- **Email:** Navigators@nchsi.org

Free language support

We give free help to people who have communication or language needs. We can give interpretation and translation support. We can also help those who need this information in different ways. Tell us if you need language support.

More information

Who accepts financial assistance?

Everyone who works for the hospital accepts financial assistance. There are a few people and groups that can give people services at the hospital who do not accept it. You can find the list here: <https://northcountryhospital.org/>. Or ask us about your doctor.

Read the full policy.

This is a plain language summary of our financial assistance policy. Read the longer version with more details here: <https://northcountryhospital.org/>. Or ask us for a free copy.

Non-discrimination

We do not discriminate based on race, color, sex, sexual orientation, gender identity, marital status, religion, ancestry, national origin, citizenship, immigration status, primary language, disability, medical condition, or genetic information.



Financial Assistance Application

Return to: NCH, 189 Prouty Drive, Newport VT 05855

802-334-3210 ext. 4204

1. Patient's Information: Self

All personal information will be held in strictest confidence.

| First Name | Last Name | Middle Initial | Date of Birth | Date |
|------------|-----------|----------------|---------------|------|
|------------|-----------|----------------|---------------|------|

| Street Address | City | State | Zip | Length at this Address |
|----------------|------|-------|-----|------------------------|
|----------------|------|-------|-----|------------------------|

| Mailing Address | City | State | Zip |
|-----------------|------|-------|-----|
|-----------------|------|-------|-----|

| Home Phone Number | Work Phone Number | Cell Phone Number |
|-------------------|-------------------|-------------------|
|-------------------|-------------------|-------------------|

2. Person Responsible for Paying the Bill

| First Name | Last Name | Middle Initial | Phone Number Home | Work | Cell |
|------------|-----------|----------------|-------------------|------|------|
|------------|-----------|----------------|-------------------|------|------|

3. ***Please list ALL people living in the household, including applicant:

Use additional paper if needed

| Name | Relationship to Patient | Age | Date of Birth | Current Health Coverage |
|------|-------------------------|-----|---------------|-------------------------|
|------|-------------------------|-----|---------------|-------------------------|

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

4. Have you applied for financial assistance at another facility? Yes No Where? _____
5. Is anyone in your household pregnant? Yes No Whom? _____
6. Is anyone in your household currently uninsured? Yes No Mark No under Current Health Care Above
7. If you are uninsured did you apply for insurance through the Health Care Exchange? Yes No
If not, why? _____
8. Have you filed a workers' compensation or motor vehicle accident claim? Yes No
If yes date of accident or injury? _____ Name of Insurance Carrier? _____ Policy # _____
9. Is anyone in your household eligible for Social Security Benefits? Yes No Who: _____
10. Has anyone applied for Medicaid? Yes No Fuel Assistance? Yes No Food? Yes No
11. Have you been denied health care? Explain _____

12. Household Income Information

Person 1

Person 2

Person 3

| NAME of Household Member | | | |
|------------------------------|----|----|----|
| (MONTHLY INCOME) | | | |
| Employment | \$ | \$ | \$ |
| Self-Employment | \$ | \$ | \$ |
| Investment Account | \$ | \$ | \$ |
| Real Estate (i.e., Rentals) | \$ | \$ | \$ |
| Unemployment | \$ | \$ | \$ |
| Retirement (Social Security) | \$ | \$ | \$ |
| Alimony | \$ | \$ | \$ |
| Public Assistance | \$ | \$ | \$ |
| Other Income | \$ | \$ | \$ |
| Specify: | | | |
| (LIQUID ASSETS) | | | |
| Checking Account | \$ | \$ | \$ |
| Savings Account | \$ | \$ | \$ |
| Certificate of Deposit | \$ | \$ | \$ |
| Money Market | | | |
| Mutual Funds/Stocks/Bonds | \$ | \$ | \$ |

| | | | |
|--|------|-------|------|
| Other Savings/Investments/Property Specify: (_____) | \$ | \$ | \$ |
| LIST OF VEHICLES | Make | Model | Year |
| Car | | | |
| Car | | | |
| Truck | | | |
| Camper | | | |
| Recreational Vehicles | | | |

PLEASE READ CAREFULLY AND SIGN BELOW

I certify that the information in this application is true and correct to the best of my knowledge. I will apply for any state, federal, or local assistance for which I may be eligible to help pay for this hospital bill. I understand that the information provided may be verified by the hospital, and I authorize the hospital to contact third parties to verify the accuracy of the information provided in this application. I understand that if I knowingly provide untrue information in this application, I will be ineligible for financial assistance, any financial assistance granted to me may be reversed, and I will be responsible for the full payment of the hospital bill.

Signature of Applicant: _____ Date: _____

Signature of Applicant: _____ Date: _____