A close up of a logo

Description automatically generated

**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 for 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:

* **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 2025, your income would need to be less than:

A table with numbers and a few dollar bills

Description automatically generated

**Low-cost care**

**You could get a 40% discount if your household income is below 400% of the Federal Poverty Level.** In 2025, your income would need to be in this range for your household size:

A table with numbers and a price

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**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.

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

**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: most recently filed federal or state income tax return; if taxes are not filed, paystubs 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 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**

* **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**

North Country Hospital provides free appropriate auxiliary aids and services to people with disabilities as well as free language assistance services to people whose primary language is not English to communicate effectively with us. These include Qualified language and sign language interpreters, information written in other languages and written information in other formats (large print, audio, accessible electronic formats, other formats). If needed, please contact NCH’s Section 1557 Civil Rights Coordinator at [patientrelations@nchsi.org](mailto:patientrelations@nchsi.org) or any clinical staff.

**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.

A close-up of a logo

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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 Email

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.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Self\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**4.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**5.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**6.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

4. Have you applied for financial assistance at another facility? YesNo Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. Is anyone in your household pregnant?  Yes No Whom? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. Is anyone in your household currently uninsured? YesNo Mark No under Current Health Care Above

7. If you are uninsured, did you apply for insurance through the Health Care Exchange?YesNo

If not, why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8. Have you filed a workers’ compensation or motor vehicle accident claim? YesNo

If yes, date of accident or injury? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of Insurance Carrier? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Policy #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

9. Is anyone in your household eligible for Social Security Benefits? YesNo Who: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

10. Has anyone applied for Medicaid? YesNo

11. Have you been denied health care? Explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

12. Household Income Information Person 1 Person 2 Person 3

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| NAME of Household Member | Are You a Tax Dependent (yes/no) |  |  |  |
| **(MONTHLY INCOME)** |  |  |  |  |
| Employment |  | $ | $ | $ |
| Self-Employment |  | $ | $ | $ |
| Investment Account |  | $ | $ | $ |
| Real Estate (i.e., Rentals) |  | $ | $ | $ |
| Unemployment |  | $ | $ | $ |
| Retirement (Social Security) |  | $ | $ | $ |
| Alimony  **Settlement Year**: \_\_\_\_\_\_\_\_\_\_\_\_\_ |  | $ | $ | $ |
| **(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 |  |  |  |  |

**PLEASE READ CAREFULLY AND SIGN BELOW**

I certify that the information in this application is true and accurate to the best of my knowledge. 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_