

**North Country Hospital**

**Summary of Financial Aid Assistance Policy**

North Country Hospital recognizes that there are times when patients in need of care will have difficulty paying for their services provided. We can help you apply for financial assistance if you qualify based on information required for the financial aid application. In addition, we can help you apply for free**, reduced** or low-cost insurance if you qualify. Financial Assistance is **NOT** considered to be a substitute for personal responsibility.

**Who qualifies for a discount?**

Financial Assistance is available for patients with limited incomes who do not have health insurance, or who have used up their health insurance services, and are ineligible for a government program, or otherwise unable to pay their medical bills.

You could get a financial aid for emergency care if your financial information provided meets the financial aid guidelines.

You could get a discount for non-emergency, medical necessary care if your financial information provided meets the financial guidelines.

You cannot be denied emergency care or other medically necessary care because you need financial assistance.

**What are the income limits?**

The amount of the discount varies based on your income and the size of your family. These are the income limits based on **2023** Federal Poverty Guidelines at 300% of the Poverty Guideline.

|  |  |
| --- | --- |
| **Family Size** | **Annual Family Income 300% of the Poverty Guideline 2024** |
|  |  |
| 1 | Up to $ 45,180 |
| 2 | Up to $ 61,320 |
| 3 | Up to $ 77,460 |
| 4 | Up to $ 93,600 |
| 5 | Up to $ 109,740 |
| 6 | Up to $ 125,880 |

**What services are covered by the hospital Financial Assistance Policy?**

All emergency services and other medically necessary services provided by the hospital including inpatient and outpatient services are covered by the Financial Assistance Policy. Professional services provided by providers who are employed by the hospital and are medically necessary are covered. Charges for professional services provided in the hospital facility by private (non-employed) providers are likely not covered. The following locations are employed by North Country Hospital.

North Country Primary Care Newport North Country Primary Care Barton Orleans

North Country Surgical Associates& Urology North Country Anesthesia & Pain Treatment Center

North Country Neurology Services North Country Ob/GYN Services

North Country Orthopedic Surgery Northern Vermont Center for Sleep Medicine

North Country Pulmonology Medicine North Country Pediatrics

North Country Radiology North Country Ears, Nose & Throat

**What Services are NOT covered by the Hospital Financial Assistance Policy**?

Services that are not medically necessary, like cosmetic surgery, infertility treatments, or services considered experimental by your health plan are not covered. Non-covered or elective services qualify for prompt discounts. Cosmetic services are already discounted.

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**How do I apply for financial assistance?**

You can apply for financial assistance by completing and submitting a Financial Aid Form to North Country Hospital or at any one of the medical clinics listed previously. **All documentation requested are required to accompany the application for NCH to complete and review eligibility.**

You may be screened for Medicaid eligibility and/or other eligible health plans and may be required to cooperate with the Financial Navigator in order to qualify for financial assistance under our policy. All insurance plans, workers’ compensation, third-party liability insurances, etc. must be billed.

**What documentation do I need to provide when I apply for financial assistance?**

* Completed Financial Assistance Form signed by all members applying for financial assistance in the household**.**
* Social Security/Pension award letter or bank statement showing Social Security Deposit**.**
* Current year’s federal income tax return including all forms and schedules**.**
* Two current consecutive bank statements**.**
* Two current paystubs/employment verification letter or one unemployment statement**.**
* Attestation letter explaining income, support, and/or current financial situation if other proof of income is not available**.**
* Medicaid notice of decision and spend down letter if applicable**.**

**How do I get financial assistance?**

You must fill out the application form. You can apply for financial assistance before you have an appointment, when you come to the hospital to get care, or when your bill comes in the mail. Eligibility shall be based upon an individualized determination of financial need and shall not take into account age, gender, race, social or immigrant status, sexual orientation or religious affiliation.

**How will I know if I was approved for assistance?**

We will send you a letter within 60 days after you submit a complete application, telling you if you have been approved and for how much of a discount will be applied.

**What if I get a bill while I am waiting to hear if I get assistance?**

You will not be required to pay a bill while our application is being considered. If your application is turned down, the hospital must tell you why in writing at which time you may submit a letter for reconsideration.

**How much do I have to pay?**

If you are eligible for financial assistance, your approved discount will be adjusted off your total outstanding self-pay balances, excluding insurance copays that are required by your insurance.

**What if I am denied financial assistance and think there was a mistake?**

You can appeal by submitting a letter in writing to the Chief Financial Officer, North Country Hospital, 189 Prouty Drive, Newport, VT 05855 within 30 days of receiving your denial letter. You can only appeal if you provided incorrect information, or there has been a change in your financial status or there is another extenuating circumstance.

**What if I get denied for assistance but cannot afford to pay my bill?**

If you get denied and still cannot pay your bill, you may be eligible for an interest-free installment payment plan. The payment plan may be based on your income or the amount of your bill. Discounts may apply.

**How do I obtain a copy of the hospital’s financial assistance policy and application?**

Copies of the hospital’s financial assistance policy, this summary, and the financial assistance application forms are all available on the internet at http://[www.north](http://www.north)countryhospital.org/financial services. Copies of these materials are also available in the offices listed above, and you can also request that copies of these materials be mailed to you (at no charge) by contacting 802-334-3210 ext. 4204 or email navigators@nchsi.org. Interpreter’s/interpretation is available upon request.



Financial Assistance Application

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

802-334-3273/802-334-3274

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. Patient’s Information: 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. SELF

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 2.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 3.

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 5.

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) | $ | $ | $ |
|  Pension/Annuities  | $ | $ | $ |
|  Alimony/Child Support | $ | $ | $ |
|  Public Assistance, Fuel, Food | $ | $ | $ |
|  Other Income  Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | $ | $ | $ |
| (ASSETS)  |  |  |  |
|  Checking Account | $ | $ | $ |
|  Savings Account/CD’s | $ | $ | $ |
|  IRA, 403B, 401 K  Specify: (\_\_\_\_\_\_\_\_\_\_\_\_\_\_) | $ | $ | $ |
|  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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_