THE University of Vermont HEALTH NETWORK
Alice Hyde Medical Center

Financial Assistance Application

Applicant's Information

Last Name | First Name | Middle Initial | Social Security Number (optional) | Date of Birth

Address | City | State | Zip Code | Home Phone # | Medical Record #

Employer — Or choose from the following options: ❒ Student ❒ Unemployed ❒ Disabled ❒ Retired

Marital Status − please choose from the following options: ❒ Single ❒ Married ❒ Separated ❒ Divorced ❒ Widowed

Spouse Last Name | Spouse First Name | Middle Initial | Social Security Number (optional) | Date of Birth

Spouse Employer — Or choose from the following options: ❒ Student ❒ Unemployed ❒ Disabled ❒ Retired

Household Information

- Please list all dependents who live in your household below
- It is not necessary to include non−dependents who reside in your household
  - **Note:** You may include dependent students (21 and under) for which you provide at least 50% support and who are reflected as dependents on your Federal Income Tax Returns.

Last Name	First Name	Social Security # (optional)	Relation to Applicant	Date of Birth

Monthly Household Expenses

This information is not required but may be useful in making a determination

❒ Mortgage ❒ Rent Amount $_____ Property tax amount NOT included in Mortgage/Rent $_____

Do you own property other than primary residence? ❒ Yes ❒ No If yes, monthly loan payment: $

Utilities	$_____	Credit Card	$_____	Insurance (auto, life, property)	$_____
Auto	$_____	Health Insurance	$_____	Alimony/Child Supp.	$_____
Child Care	$_____	Healthcare Bills	$_____	Other:	$_____
Living (gas,food,etc.)	$_____	Medications	$_____	Other:	$_____

Additional Information

Are you covered under any health insurance policy? ❒ Yes ❒ No
If yes, list insurance(s):_____

Are you seeking Financial Assistance for services resulting from any of the following? ❒ Yes ❒ No
☐ Work Related ☐ Liability ☐ Motor Vehicle

Do you have an application pending for insurance on the Health Exchange or State Aid such as Medicaid, or NY Essential Health Plan? ❒ Yes ❒ No

Did you file and/or are you required to file a Federal Tax Return? ❒ Yes ❒ No
You may wish to provide copies of your current Federal Income Tax Return (optional)

If No, why?_____

Do you reside in New York greater than 6 months per year? ❒Yes ❒No

Income

MONTHLY INCOME FROM: Person 1 Person 2

Name of household member: _____ _____

			Documentation required for verification **Optional
Gross Salary Wages	$	$	2 consecutive pay stubs/empl. pay stmt
Self Employed	$	$	**Tax return plus current YTD profit/Loss
Social Security	$	$	Award letter, check stub, bank stmt
Worker's Compensation	$	$	Check, bank stmt, online, etc.
Unemployment	$	$	Check, bank stmt, online, etc.
Alimony/Child Support	$	$	Cancelled check, garnishment, bank stmt.
Pension/Retirement Income	$	$	Bank stmt or Pension check stub
Disability	$	$	Check, bank stmt, online, etc.
Rental Income	$	$	Schedule E of IRS tax form
Dividend Income	$	$	Current/Quart. stmt from fin. institution
Other Income	$	$	Contact FAP Specialist
Total:	$	$	
Cash & Savings			
Checking Acct. Balance	$	$	Bank Statement
Savings Account	$	$	Bank Statement
Total:	$	$	

Acknowledgement − Please Read Carefully

I am requesting Financial Assistance from The University of Vermont Health Network − Alice Hyde Medical Center. I verify that all information I have provided is accurate and complete. The University of Vermont Health Network − Alice Hyde Medical Center has my permission to pursue verification of pertinent information and any incorrect, incomplete or false information provided may cancel my application for Financial Assistance. I agree to repay the full Financial Assistance award if I receive payment of any kind for the medical services covered by this Financial Assistance application. The University of Vermont Health Network − Alice Hyde Medical Center is authorized to access credit bureau files and reports, now and in the future for collection purposes. All information provided will remain confidential under the provisions of HIPPA federal regulations.

_____ _____

Signature of Patient (Parent/Guardian if Patient is under 18) Date