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 or low-cost insurance if you qualify.

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 benefits.

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

You can 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 2020 Federal Poverty Guidelines at 300% of the Poverty Guideline.

Family Size	Annual Family Income 300% of the Poverty Guideline 2020
1	Up to $ 38,280
2	Up to $ 51,720
3	Up to $ 65,160
4	Up to $ 78,600
5	Up to $ 92,040
6	Up to $105,480

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 Surgical Associates& Urology
North Country Neurology Services
North Country Orthopedic Surgery
North Country Pulmonology Medicine
North Country Radiology
North Country Primary Care Barton Orleans
North Country Anesthesia & Pain Treatment Center
North Country Ob/GYN Services
Northern Vermont Center for Sleep Medicine
North Country Pediatrics
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.

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.

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.

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 much do I have to pay?

If you are eligible for financial assistance, you will not be charged other than the co-payments required by your health plan.

How do I get financial assistance?

You have to 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. You will have 240 days after getting your first bill from us to submit your application.

How will I know if I was approved for assistance?

We will send you a letter within 30 days after you submit a complete application, telling you if you have been approved.

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

You cannot 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.

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.

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.northcountryhospital.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 802-334-3274, 802-334-3273 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.					
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's 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(Since __/__/__)	$	$	$
Retirement (Social Security)	$	$	$
Pension/Annuities	$	$	$
Alimony/Child Support	$	$	$
Public Assistance, Fuel, Food	$	$	$
Other Income Specify: _________________	$	$	$
SAVINGS/INVESTMENTS			
Checking Account	$	$	$
Savings Account/CD's	$	$	$
IRA, 403B, 401 K Specify: (______________)	$	$	$
Mutual Funds/Stocks/Bonds	$	$	$
Other Savings/Investments Specify: (_______________)	$	$	$
LIST OF VEHICLES	Make	Model	Year
Car			
Car			
Truck			
Camper			
Recreational Vehicles			

13. Household Expenses- Monthly (if Yearly Specify –Yr)

Monthly Rent Payment: $______________ Monthly Mortgage Payment: $_________________

Value Primary Residence: $______________ Property Tax Listing $_________________ Mortgage Balance: $_________________

Other Property: Value $______________ Property Tax Listing $_________________ Mortgage Balance: $_________________

Type of Property Owned and Value if additional properties:

Mobile Home: $______________ Farm: $______________Camp: $_____________ Acreage: $______________ Business: $_______________

Utilities	$	Insurance(Auto/Life)	$	Property Insurance	$
Heat	$	Gas/Food	$	Health Care Bills	$
Child Care	$	Alimony/Child Support	$	Medications	$
Cable/TV/Intranet	$	Credit Card:	$	Other:	%

14. Liabilities/Loans/Mortgage (Mortgage, School, Credit Card Debt, Vehicles, other)

Name of Creditor	What Purchased	Amount Financed	Unpaid Balance	Monthly Payment
		$	$	$
		S	$	$
		$	$	$
		$	$	$
		$	$	$
			Total: $	Total: $

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: ______________________________

Signature of Applicant: ____ Date: ______________________________