Where People Come First

FINANCIAL ASSISTANCE APPLICATION

100 River Street, P.O. Box 2003
Springfield, Vermont 05156
Phone: 802-886-8959, ext. 1506 or 885-1616
Fax: 802-885-2030

Springfield Medical Care Systems (SMCS) is a non-profit healthcare corporation serving portions of Windsor, Windham and Bennington Counties, Vermont and portions of Sullivan and Cheshire Counties, New Hampshire. SMCS operates the SMCS Community Health Center (CHC) network which provides primary and preventative care at community health center locations dispersed throughout the service area. A subsidiary of SMCS, Springfield Hospital, (with campuses in Springfield and Bellows Falls, VT) provides acute care services, including mental health, and also operates specialty physician practices.

SMCS is committed to meeting the needs of the residents of its defined service area by offering a sliding fee scale to all income-eligible uninsured or underinsured patients based on annual household income. SMCS will provide, without discrimination, care for emergecy medical conditions to individuals regardless of their eligibility to pay under the financial assistance policy.

SMCS offers a Financial Assistance Program (FAP) to reduce the burden of medical expenses for patients who demonstrate financial need. The FAP provides discounted care based upon family income in relation to Federal Poverty Level guidelines.

There is no residency requirement for medical services provided by the SMCS Community Health Center Network (CHC), including dental and ophthalmology.

1. In order to be eligible for assistance for services provided by Springfield Hospital, the patient/guarantor must be a resident of the State of Vermont, or Sullivan or Cheshire Counties in New Hampshire. Applicants who reside outside Vermont or the indicated New Hampshire counties, and who have been deemed eligible for assistance for CHC services, may also be deemed eligible for Springfield Hospital assistance.
2. In order to be eligible for financial assistance for the 340B prescription drug program, applicants must have selected the CHC as their primary care provider or reside in one of the following Vermont towns: Andover, Athens, Baltimore, Cavendish, Chester, Grafton, Jamaica, Landgrove, Londonderry, Ludlow, Mt. Holly, Peru, Plymouth, Reading, Rockingham (Bellows Falls), Springfield, Stratton, W.Windsor, Weathersfield, Westminster, Weston, and Windham or NH towns of Acworth, Alstead, Charlestown, Langdon, and Walpole.

If you need help completing the SMCS FAP application, or your application for Vermont/NH Medicaid included in this packet, please call 802-886-8959 or 802-885-1616. A face-to-face appointment can greatly expedite the eligibility determination process.

This financial assistance application is for services provided and billed by Springfield Medical Care Systems. If you are declared eligible for financial assistance, your eligibility will be in effect for one year. It is your responsibility to notify Springfield Medical Care Systems of any bills that you receive from the date that you made application and the date you are notified of approval.

PLEASE NOTE:

- ❑ For your application to be considered for financial aid, you must submit all documentation requested within 30 (thirty) days of the receipt of the application.
- ❑ Correctly filling out the application is not a guarantee of financial aid.
- ❑ SMCS will not grant financial aid for any elective procedures for any patient account.

WE REQUIRE ALL OF THE FOLLOWING INFORMATION TO COMPLETE YOUR APPLICATION.

- ❑ A complete copy of your most recent income tax return or other tax return on which you are claimed as a dependent.
- ❑ If you own a business, business taxes and the last three consecutive months ledgers. Please be sure to include a copy of your schedule C.
- ❑ A copy of one month's recent pay stubs for all employers.
- ❑ A statement of unemployment benefits for all household members receiving benefits.
- ❑ A statement of any cash assistance from the State in which you live.
- ❑ A statement of Social Security benefits for all household members receiving benefits.
- ❑ A Workers Compensation Benefit statement.
- ❑ The patient and/or guarantor are encouraged to maintain coverage through New Hampshire Medicaid or Vermont Medicaid.
- ❑ SMCS requires two recent, consecutive monthly bank statements for each account held by a person applying on the application (savings, checking, etc.)
- ❑ You must sign your application.

5-13-20

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FINANCIAL ASSISTANCE NOTICE

Listed below are services that ARE and ARE NOT covered by our Financial Assistance Program.
****** Please read this letter carefully ******

COVERED SERVICES

Springfield Medical Care Systems' (SMCS) and Springfield Hospital's (SH) financial assistance is only for services billed by SMCS and SH, and applies only to medically–necessary services. Elective services are not covered. Most other services are covered under the financial assistance policy, including visits to your primary care doctor. Patients are encouraged to inquire prior to having medical treatment as to whether or not the service is covered by the financial assistance policy.

SERVICE AREA ELIGIBILITY

Please see the SMCS Financial Assistance Application for details regarding the service area eligibility.

CONTRACTED SERVICES

Please note the following company **DOES** contract with our financial assistance program.

- Bluewater Emergency Partners

Should you receive a bill from this company, please mail them a copy of your financial assistance award letter that shows the percentage you were granted. It is your responsibility to send them a copy of your financial assistance award letter to avoid collections. Should you be sent to collections, your financial assistance can no longer be applied.

SERVICES NOT COVERED

Services excluded under our Financial Assistance Program for Springfield Medical Care Systems (SMCS), Springfield Hospital (SH), and Springfield Specialties (SSP) are as follows:

Elective services are not covered. Patients are encouraged to inquire prior to having medical treatment as to whether or not the service is covered by the financial assistance policy.

Cytology for pap smears and HPV testing. Cheshire Medical Center Pathology and Dartmouth-Hitchcock provide cytology for pap smears & HPV testing. These services may not be covered under our financial assistance program.

Services provided by hospitals or companies that are not owned by SMCS or Springfield Hospital. Example: Brattleboro Obstetrics & Gynecology, Clinical Colleagues (anesthesia), Cheshire Medical Center, Dartmouth Hitchcock, and vRad (radiology services). Services may be performed at Springfield Hospital that are not covered under our financial assistance program. Should you receive a bill from them, please call them and inquire about their programs.

Missed appointments. Please note that financial assistance does not apply for 'no shows' for physician appointments.

QUESTIONS

If you have a question about covered services, please contact: Penny Bixby, Patient Financial Counselor, 100 River Street, Springfield, VT 05156 Phone: 802-886-8959- Extension 1506. Email: pbixby@springfieldmed.org.

If you have questions on bills or payment policies, please call Patient Business Services at 802-886-8950.

Springfield
Medical Care Systems, Inc.

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25 Ridgewood Road, P.O. Box 2003
Springfield, Vermont 05156
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Fax: 802-885-2030

FINANCIAL ASSISTANCE APPLICATION

Please attach all income verification and send the application to:

- ☐ Springfield Medical Care Systems
  Attn: Patient Business Services
  P. O. Box 2003, Springfield, VT 05156
  Phone: 802-886-8959 ext 1506 Fax: 802-885-2030
- ☐ Valley Health Connections
  268 River Street, Springfield, VT 05156
  Phone: 802-885-1616 Fax: 802-885-3324

This application is intended to provide Springfield Medical Care Systems with information concerning your financial status. It will be used to determine your eligibility for financial assistance.

You must sign the back page

Please print:

Patient Name

______________________________ DOB______________

Social Security Number______________________________

Street or PO Box______________________________

City______________________ State______________ Zip______________

Home Phone ______________ Cell ______________ Work ______________

Please circle the kind of insurance you have: Commercial Medicare Medicaid None

Primary Care Provider

____

Number of persons living in household ________.

Please list all names of household residents and dependents, including DOB:

(attach additional paper for dependents if needed.)

If anyone listed below is also applying for financial assistance, please circle **yes** or **no**. (*If applying, please provide SS #.*)

Name	Social Security #	Relationship	DOB	Applying
				Y / N
				Y / N
				Y / N

Please provide financial information for those in the categories below:

- Yourself (If you are 18 or older and are claimed on your parent's federal income tax return, you should submit your parent's proof of income).
- Your spouse, civil union partner, or parent of your minor child living with you.
- Your children who are claimed on your most recent Federal Tax Return.

Food Stamps/Subsidy: Do you receive Food Stamps? Yes___ No___ Housing Subsidy? Yes____ No____

Employment: Are you presently employed? Yes_______ No ______

Total Current Gross Monthly Income: (Please include spouse and children's social security income.)

Salary/Wages______________________ Interest Dividends______________________

Social Security Retirement ______________________ Worker's Compensation______________________

Supplemental Social Security (SSI)______________________ Veteran's Benefits______________________

Social Security Disability (SSDI) ______________________ Pension/Retirement______________________

Unemployment ______________________ Self Employment/Farm Income ______________________

Alimony/Child Support______________________ Rental Income ______________________

Other: Please specify ______________________________

Monthly Total______________ **Annual Adjusted Gross Income from previous year tax return** ______________

Please complete the following:

Signature is required at the bottom of this page.

ASSETS (Items you own)	**Name of Bank**	**Balance**
Checking		
Savings		
Stocks/Bonds/Investments		
IRAs		
Other *(Example: Certificate of Deposit)*		
TOTAL		

DEBTS (living expenses)	**Creditor Name**	**Monthly Payment**	**# of Months Past**
Due			
Rent			
Mortgage			
Mortgage			
Insurance			
Real Estate Taxes			
Auto Loan			
Alimony			
Spousal Support			
Child Support			
Electric			
Fuel			
Medical (other than SMCS)			
Physicians			
Telephone			
Credit Card			
Credit Card			
Other			
Other			
TOTAL			

I certify that the information I have provided to determine eligibility is true and correct. I hereby authorize Springfield Medical Care Systems to verify my past and present employment and earnings records. The information obtained is to be used in processing my application for financial assistance.

Signature of Applicant **Date**

Name (Please print)

Rev. 5-13-20