North Star HEALTH

Springfield Hospital

FINANCIAL ASSISTANCE APPLICATION

North Star Health (NSH) and Springfield Hospital are non-profit healthcare corporations serving portions of Windsor, Windham and Bennington Counties, Vermont and portions of Sullivan and Cheshire Counties, New Hampshire. NSH operates the Community Health Center (CHC) network which provides primary and preventative care at community health center locations dispersed throughout the service area. Springfield Hospital (SH), with campuses in Springfield and Bellows Falls, VT, provides acute care services, including mental health, and also operates specialty physician practices.

NSH and SH are 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; and will provide, without discrimination, care for emergecy medical conditions to individuals regardless of their eligibility to pay under the financial assistance policy.

NSH and SH offer 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.

This financial assistance application is for services provided and billed by NSH and SH. If you are declared eligible for financial assistance, in most cases your eligibility will be in effect for one year. It is your responsibility to notify NSH and SH of any bills that you receive from the date of your completed 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.

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 VT or NH 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. ☐

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

North Star Health's (NSH) and Springfield Hospital's (SH) financial assistance is only for services billed by NSH 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

There is no residency requirement for medical services provided by North Star Health's Community Health Center Network (CHC), including dental and ophthalmology.

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.

In order to be eligible for financial assistance for the 340B prescription drug program through NSH, 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 financial assistance application, or your application for Vermont/NH Medicaid included in this packet, please call 802-885-7081, ext. 7785 or 802-885-1616. It is always best to call prior to submitting your application..

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 North Star Health (NSH, 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.

Cytology for pap smears & HPV testing may not be covered under our financial assistance program.

Services provided by hospitals or other healthcare providers that are not owned by North Star Health or Springfield Hospital.

Example: Brattleboro Obstetrics & Gynecology, anesthesia providers, Cheshire Medical Center (cytology), Rutland Regional Medical Center or University of Vermont (pathology), and Dartmouth Hitchcock (radiology services). Services may be performed at Springfield Hospital that are not covered by our financial assistance program. Should you receive a bill from other healthcare providers, please call them and inquire about their programs. Additional information about Springfield Hospital physician participation in the financial assistance program can be found by visiting physician profile pages at www.springfieldhospital.org.

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

QUESTIONS

If you have a question about covered services, please contact:

Valley Health Connections, 268 River Street, Springfield, VT 05156 Phone 802-885-1616; or
Patient Business Services, 192 Park Street, Springfield, VT 05156 Phone: 802-885-7081- Extension 7785.
Email: fap@springfieldhospital.org.

7-15-22

North Star HEALTH

Springfield Hospital
Where People Come First

FINANCIAL ASSISTANCE APPLICATION

Please attach all income verification and send the application to:

❑ Patient Business Services
P. O. Box 2003, Springfield, VT 05156
Phone: 802-885-7081 ext 7785 Fax: 802-885-8153

❑ Valley Health Connections
268 River Street, Springfield, VT 05156
Phone: 802-885-1616 Fax: 802-885-3324

This application is intended to provide North Star Health and SH 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 NSH/SH)			
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 North Star Health and/or Springfield Hospital 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)

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