Po Box 216
Townshend, VT 05353
802-365-3647
www.gracecottage.org

Grace Cottage Hospital / Grace Cottage Family Health
Reduced Fee / Free Care Application

Responsible Party Information (Please Print)

Name_____
First/ Middle/ Last

Date of Birth_____/_____/_____ **Telephone** (____)_____

Current Residence_____
Street City State

Current Mailing _____
Street / Po Box

_____
City State Zip Code

Presently Employed?
Yes or No
Employer's Name: **Date last Worked?**
Address:
Phone:
Length of Employment:

Spouse/Partner Employed?
Yes or No
Employer's Name: **Date last Worked?**
Address:
Phone:
Length of Employment:

HOUSEHOLD INFORMATION:
How many people are residing in your home, including yourself? _____

Please list everyone residing in your home and their relationship to you:

Full Name	Date of Birth	Relation to You	Monthly Income
1.			
2.			
3.			
4.			
5.			
6.			
7.			

If you need more space, list additional people on a separate piece of paper and attach to this application.

Health Insurance

BCBS- ID#_____

Medicare- ID#_____

Cigna- ID#_____

MVP- ID#_____

Medicaid-ID#_____

Other:_____**ID#**_____

Have you applied for Green Mountain Cares Program? **Yes or No**
(Medicaid / VHAP/ Dr. Dinosaur) **If denied, please explain why below.**

_____
_____
_____
_____
_____
_____

Monthly Income

Gross Household Wages (before taxes)	$
Self-Employment after deductions from Schedule C (excluding depreciation)	$
Interest Income	$
Child Support / Alimony Received	$
Rental Property Income	$
Pension / Retirement / Unemployment / Workmen's Comp	$
Other:	$
Total Monthly Income (before taxes)	$
Total Yearly Income (before taxes)	$

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ASSETS

Please list your household's financial assets.

	Financial Institution	Account Number	Balance in Account	Documentation Required
Checking Accounts	1. 2. 3.			Please Provide: **3 consecutive months of bank or other financial statements.**
Savings Accounts	1. 2. 3.			Please Provide: **3 consecutive months of bank or other financial statements.**
Real Estate Value	1. 2. 3.			Please Provide: **Documentation (tax bill, mortgage agreement, tax return) that clearly identifies Real Estate Value for all properties owned.**
Total Account Balances:				

If you have more than 3 checking or savings accounts please include an additional sheet of paper listing them.

I certify that the information provided above is an accurate and true representation of my financial information. I also certify that there is no additional insurance coverage for this patient. I understand that providing false information will result in denial of the application for any type of financial assistance through Grace Cottage Hospital and/or Grace Cottage Family Health (GCH/GCFH). If I am entitled to any action against or settlement from third party payers, I will take any action necessary or requested by GCH/GCFH to obtain such assistance and will assign to GCH/GCFH, and upon receipt, will pay GCH/GCFH, all amounts recovered up to the total amount of the outstanding balance on my bill. My failure to apply for such assistance or follow through with the application process or take those actions reasonably necessary or requested by GCH/GCFH will result in the denial and/or revocation of this application.

If you have any questions, please feel free to contact Verna Joslyn of the Finance Department at GCH/GCFH 802-365-3647.

Required Documentation

Applications received without supporting documents cannot be processed and will be returned to you.

1. Does anyone in your household receive Social Security Benefits or Disability Benefits? Yes or No

If yes, please include current **copies of current benefit statement**. To obtain a copy of this, please call the Social Security Office at 1-866-690-2025.

2. Does anyone in your household receive Unemployment Benefits or Pension/Annuity Benefits? Yes or No

If Yes, please provide **copies of current benefit statements.**

3. Is anyone in your household required to file Federal Income Taxes? Yes or No

If yes, please provide a **copy of your most recent Federal Income Tax return(s), including all schedules,** for each member of your household and **90 days' worth of pay stubs from all employers**. To obtain a copy of your tax return(s), please call 1-800-829-1040.

4. Is anyone in your household self-employed? Yes or No

If yes, please provide **copies of the most recent Business Tax Return** including Schedule C.

If you are unemployed and there is no income coming into the household, a written letter explaining how you are supporting yourself is required.

Please provide a written statement of any other extenuating circumstances that you would like us to know about. If applying for Reduced Fee/Free Care on balances aged more than 30 days this written statement will be required for consideration.

For Office Use Only:

APPROVED _____ % Discount or DENIED: Income ☐ SA ☐ Other ☐

Account Balance after RFA: _____ Patient Called ☐
Minimum Monthly Payment: _____ Letter Sent to Patient ☐
Account Adjusted ☐

Patient / Guarantor will pay:
Balance in Full ☐ or Monthly Payment _____

Approved By _____

Approved Date _____

Signature of Applicant: _____ **Date:** _____