Gifford Medical Center

Thank you for your interest in the Gifford Affordable Care Program. Prior to making a determination on your request, we will need you to supply us with your household financial information.

We require proof of income. Please send us a COPY any of the following that apply:

- Complete copies of your most recent Federal Income Tax Return (Including your 1040, 1040EZ, 1040A, etc.)
- Last year's W-2 form
- Paycheck stubs from the last three months or a statement from your employer
- Unemployment or disability compensation benefits
- Pension (including Social Security) benefits
- Copies of most current tax return if self employed, including copies of Schedule C or F, and all other schedules
- VHAP or Medicaid decision

Please call me directly if you have any questions, or if you are having problems supplying the information requested. My telephone number is (802) 728-2323.

Please remember to sign and date your application.

Your application must be completed in full and all pages sent back to me within 30 days. Incomplete applications will not be processed.

Michele M Packard

Michele Packard
Health Connections Case Manager

Gifford Medical Center

Gifford Affordable Care Program application

Patient's name: _____

Patient's date of birth: _____ Patient's Social Security #: _____

Address: _____

Your name: _____ Telephone #:_____

Your date of birth: _____ Your Social Security #: _____

Part 1: Financial analysis worksheet

Household expenses	Monthly amount	Financial institution(s)	Outstanding balance
Mortgage/rent			
Credit card(s)			
Personal loan			
Automobile loan			
Home insurance			
Health insurance			
Life insurance			
Doctors owed			
Hospitals owed			
Pharmacy			
Other medical			
Telephone			
Food			
Heat			
Electricity			
Fuel (gas)			
Water and sewer			
Rubbish			
Taxes			
Transportation			
Childcare			
Personal/other			

Total monthly expenses: _____

Gifford Medical Center

Part 1: Financial analysis worksheet (continued)

Gross income	**Monthly amount**
Wage	
Social Security	
Worker's compensation	
Unemployment benefit	
Alimony/child support	
Pension	
Disability	
Rental income	
Public assistance	
Food stamps	
Fuel assistance	
Other	

For office use only:

Total monthly income minus total monthly expenses:

_____

Notes: _____
_____
_____
_____
_____
_____
_____
_____

Total monthly income: _____

If there is no income or if there is a negative cash flow, explain how living expenses are being met: _____
_____
_____
_____

Assets	**Total**
Property (assessed value)	
Stocks, bonds, mutual funds	
Checking account balance	
Savings, CDs balance	
Retirement accounts	
Other	

Total assets: _____

Gifford Medical Center

Part 2: Household information

Household member (list all names)	Date of birth	Relationship	Social Security #	Medical record #

Part 3: Current health insurance information

Primary insurance company: _____

Address: _____

Group #: _____ ID #:_____ Start date: _____

Name of insured: _____ Telephone #: _____

Address: _____

Date of birth: _____ Patient's relationship to insured: _____

Insured's employer: _____ Telephone #: _____

Address: _____

Secondary insurance company: _____

Address: _____

Group #: _____ ID #:_____ Start date: _____

Name of insured: _____ Telephone #: _____

Address: _____

Date of birth: _____ Patient's relationship to insured: _____

Insured's employer: _____ Telephone #: _____

Address: _____

Part 4: Other

Please share additional employment information, such as seasonal, part-time or temporary work or layoffs. _____

_____

_____

_____

Are you a veteran? _____

If unemployed, what was your last day of work? _____

If returning to work, will you return to the same employer? _____

I am applying for (please check one): ☐ Medical services already received

☐ Future medical services

Part 5: Sign and date

I, the undersigned, certify that the above facts are accurate and true, and I realize that any falsification will cancel any approval of a bill reduction for services rendered at Gifford Medical Center. I give permission for Gifford Medical Center to verity any statement made above.

Signature: _____ Date: _____

Part 6: Checklist

To ensure that your application will be processed quickly, please complete the following checklist.

- ☐ I signed and dated my application.
- ☐ I enclosed a complete copy of my most recent tax return.
- ☐ I enclosed COPIES of three months recent pay stubs.
- ☐ I enclosed COPIES of Social Security checks, unemployment, food stamps or general assistance documentation.

If you did not enclose a copy of last year's tax return, please indicate the reason why:

- ☐ I do not have to file. I am retired.
- ☐ I did not make enough money to file.
- ☐ I did not keep a copy of last year's tax return.