Gifford Health Care

44 South Main Street, Randolph, Vermont 05060
www.giffordhealthcare.org

Thank you for your interest in the Gifford Affordable Care Program. We have two affordable care options; one for people earning less than or equal to 200% of the federal poverty level that will provide service under a Federal Qualified Health Center (FQHC) sliding scale fee program, and one for services to those household whose income exceeds the 200% federal poverty level and are therefore not eligible for the FQHC sliding scale fee program.

To apply, you must complete an application and return it to our Billing Office as soon as possible. Our office will review the application and notify you of your eligibility for the Gifford Affordable Care Prgram within ten (10) business days. Until this process is completed, you will be responsible for any charges in full for any services received. Your Affordable Care rate will be a sliding fee (a fee based on your ability to pay), and it is good for twelve months from the date your application is approved. However, should your finanical circumstances change in that time, you are obligated to report that to Gifford. To continue receiving an Affordable Care sliding fee after one years, you must go through the entire application process again.

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 provide a COPY of any of the following that apply:

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

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

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.

Thank you for your interest and effort.

Michele M Packard

Michele Packard

Health Connections Case Manager

Gifford Health Care

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 (to be completed by individuals/households with incomes in excess of 200% of poverty guidelines)

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: _____

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Part 2: Financial analysis worksheet (to be completed by all applicants)

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:

_____

_____

Part 3: Household Information

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

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Part 4: 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 5: Other

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

_____

_____

Are you a veteran? ☐ Yes ☐ No

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 6: 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. I give permission for Gifford to verity any statement made above.

Signature: _____ Date: _____

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Part 7: 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.

Part 8: Question

If you're reapplying for the sliding fee discount, did Gifford's Affordable Care Program make it easier for you to access care?

- ☐ YES
- ☐ NO
- ☐ Don't know