Gifford

Gifford Sliding Fee Discount Financial Assistance Application

Gifford Health Care and Gifford Medical Center provide emergency and medically necessary care to individuals regardless of ability to pay, eligibility for financial or government assistance, age, gender, race, social or immigrant status, sexual orientation, or religious affiliation. Patients eligible for financial assistance will not be charged more than amounts generally billed (AGB) to individuals who have insurance coverage. **Please complete the following information and return to any Gifford Health Care location or mail to: Gifford Health Care, PO Box 2000, Attn: Financial Assistance Coordinator, Randolph, VT 05060. For questions please call 802-728-2323.**

PATIENT INFORMATION					
Patient's name:					
Address:			Town	State, ZIP	
Date of Birth:		Telephone #:	( )		
Primary Care Provider:			Date of last appointment with provider:		

DEPENDENT INFORMATION: *(Please note: only dependents you claim on your Federal tax return may be included here – attach a piece of paper for additional dependents if needed)*

Household member(s):	Date of Birth	Relationship	Gifford Patient	Primary Care Provider	Applying
			☐ Yes ☐ No		☐ Yes ☐ No
			☐ Yes ☐ No		☐ Yes ☐ No
			☐ Yes ☐ No		☐ Yes ☐ No
			☐ Yes ☐ No		☐ Yes ☐ No

Please return this form with each of the following forms of income verification:

- Most recently filed tax return (IRS form 1040)
- Most recent IRS Form W2 or 1099
- Paystubs from the past 30 days
- Copy of most recent Saving Account Bank Statement(s)
- Copy of most recent Checking Account Bank Statements(s)

Additional information that can be provided, if applicable and available:

- Social Security, disability or pension benefits statements
- Unemployment benefits statement
- FAFSA form

If you have no income, tell us how your daily living expenses are paid.

_____

ADDITIONAL INFORMATION			
Are you homeless?	☐ Yes	☐ No	
Are you a College student?	☐ Yes	☐ No	
Can you be claimed as a dependent on someone else's tax return?	☐ Yes	☐ No	☐ Don't know
Are you currently eligible for Medicaid?	☐ Yes	☐ No	☐ Don't know
Are you enrolled in Vermont Health Connect?	☐ Yes	☐ No	☐ Pending
Do you or your spouse have dental insurance?	☐ Yes	☐ No	☐ Don't know
Can you afford medications?	☐ Yes	☐ No	☐ Don't know
Did you delay treatment because you could not afford it?	☐ Yes	☐ No	☐ Don't know
Are you reapplying for the sliding fee discount scale?	☐ Yes	☐ No	
If yes, does Gifford's financial assistance program make it easier to access care?	☐ Yes	☐ No	☐ Don't know

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CURRENT HEALTH INSURANCE INFORMATION			
Primary Insurance Company:			
Address:		Town	State, ZIP
Group Number:		ID Number:	
Secondary Insurance Company:			
Address:		Town	State, ZIP
Group Number:		ID Number:	

Where did you receive medical care:
☐ Doctor's Office ☐ Emergency Room
☐ WICC/urgent care ☐ Chiropractor

When did you last receive medical care:
☐ 0-6 months ☐ 6 months to 1 year ☐ 1-2 years
☐ 2-5 years ☐ >5 years

If not here, where would you have gone for care?
☐ Doctor's Office ☐ Emergency Room
☐ WICC/Urgent care ☐ Would not seek care

Education:
☐ 8th Grade or less ☐ Some High School ☐ High School/GED
☐ Some College ☐ Associate's Degree ☐ Bachelor's
☐ Masters ☐ Doctorate

Smoking History:
☐ Smoker ☐ Interested in Quitting ☐ Non-Smoker

Sign and Date

I, certify that the information shown above is correct, and understand that verification is required for approval. Also, I understand that any false statements, documents or concealment of a material fact will disqualify me from receiving sliding fee discounts. I understand that it is my responsibility to report any changes in income immediately to Gifford Health Care.

_____ _____

Signature Date

Office Use Only			
Approval Discount:	Date Approved:	Verification of Income:	Notes: