



## 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:			
<b>DEPENDENT INFORMATION:</b> <i>(List dependents you claim on your Federal tax return—attach a piece of paper for additional dependents if needed. Domestic partnership, married filing separately or separated, notify your financial counselor)</i>					
Household member(s):	Date of Birth	Relationship	Gifford Patient	Primary Care Provider	Applying
			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No

Please return this form with the following preferred form of income verification:

- Most recently filed tax return (IRS form 1040)

If recently filed tax returns are not available, do not reflect current income, or if you are not required to file federal income tax returns, please provide the following information if applicable and available:

- Paystubs from the past 30 days
- Copy of recent Bank Statement(s)
- Profit and loss statement
- Social Security, disability or pension benefits statements
- Unemployment benefits statement
- Documentation of public assistance

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

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ADDITIONAL INFORMATION		
Are you homeless?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you a College student?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Can you be claimed as a dependent on someone else's tax return?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't know
Are you currently eligible for Medicaid?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't know
Are you enrolled in Vermont Health Connect?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Pending
Do you or your spouse have dental insurance?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't know
Can you afford medications?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't know
Did you delay treatment because you could not afford it?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't know
Are you reapplying for the sliding fee discount scale?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, does Gifford's financial assistance program make it easier to access care?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> 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:
- |   |   |
|---|---|
| <input type="checkbox"/> Doctor's Office  | <input type="checkbox"/> Emergency Room |
| <input type="checkbox"/> WICC/urgent care | <input type="checkbox"/> Chiropractor   |
- When did you last receive medical care:
- |                                     |   |                                    |
|-------------------------------------|---|------------------------------------|
| <input type="checkbox"/> 0-6 months | <input type="checkbox"/> 6 months to 1 year | <input type="checkbox"/> 1-2 years |
| <input type="checkbox"/> 2-5 years  | <input type="checkbox"/> >5 years           |                                    |
- If not here, where would you have gone for care?
- |   |  |
|---|--|
| <input type="checkbox"/> Doctor's Office  | <input type="checkbox"/> Emergency Room      |
| <input type="checkbox"/> WICC/Urgent care | <input type="checkbox"/> Would not seek care |
- Education:
- |  |   |  |
|--|---|--|
| <input type="checkbox"/> 8 <sup>th</sup> Grade or less | <input type="checkbox"/> Some High School   | <input type="checkbox"/> High School/GED |
| <input type="checkbox"/> Some College                  | <input type="checkbox"/> Associate's Degree | <input type="checkbox"/> Bachelor's      |
| <input type="checkbox"/> Masters                       | <input type="checkbox"/> Doctorate          |  |
- Smoking History:
- |                                 |   |                                     |
|---------------------------------|---|-------------------------------------|
| <input type="checkbox"/> Smoker | <input type="checkbox"/> Interested in Quitting | <input type="checkbox"/> 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: