VERMONT PUBLIC HEALTH INSURANCE

Dr. Dynasaur

Provides low cost or free health care coverage for children, teens under age 18, and pregnant women.

Eligibility is based on household income and family size.

Vermont Health Access Program (VHAP)

Provides low cost, low income adjusted healthcare coverage for those age 18 and older who have been uninsured for 12 months or more.

Eligibility is based on household income and family size.

Medicaid

Provides low cost or free health care coverage for children, young adults under age 21, parents, pregnant women, caretaker relatives, people who are blind or disabled and those age 65 and older.

Eligibility is based on household income and family size.

Catamount Health

Provides low cost healthcare coverage for Vermonters age 18 or older and families who are not eligible for existing State programs such as Medicaid and VHAP, who have been uninsured for 12 months or more. There are exceptions for those who have lost insurance coverage because of a life change, OR, who have had insurance coverage for the last 6 months with a deductible of $10,000 or more for individuals or $20,000 or more for a family, and who do not have access to health insurance through an employer.

Eligibility is based on household income and family size.

Information or Applications for the State Programs can be obtained from The Vermont Department for Children and Families at 800.287.0589 or visit: www.greenmountaincare.org

PORTER HOSPITAL & PORTER PRACTICE MANAGEMENT FINANCIAL ASSISTANCE PROGRAM

OUR FINANCIAL ASSISTANCE PROGRAM

Dear Patient,

Reduced fees or Free Care for required medical services are available to patients who are eligible for the Porter Hospital financial assistance policy.

You may apply for these services by filling out the enclosed application.

Proof of Family Unit Income (household) will be required before a definite determination can be made. Please mail or deliver proof of income to our office, along with the completed application form contained in this packet, to: Porter Practice Management, 104 Porter Drive, Middlebury, VT 05753

Sincerely,

Kris Newton
Porter Practice Management
388-5673

Kathy Wright
Porter Hospital
388-4729

SLIDING FEE SCALE

Our sliding fee scale (below) is based on federal guidelines which are revised annually for family size and income. Based on the eligibility requirements, you may qualify for a fee reduction of **20% up to 100%** for required medical services. Please note that elective and non-medically necessary services are not eligible for sliding fee scale consideration.

Family size	Income	Discount
Single	Income of $32,685	20% discount
	Income of $30,506	40% discount
	Income of $28,327	60% discount
	Income of $26,148	80% discount
	Income of $21,780	100% discount
Family of 2	Income of $44,130	20% discount
	Income of $41,188	40% discount
	Income of $38,246	60% discount
	Income of $35,304	80% discount
	Income of $29,420	100% discount
Family of 3	Income of $55,590	20% discount
	Income of $51,884	40% discount
	Income of $48,178	60% discount
	Income of $44,472	80% discount
	Income of $37,060	100% discount
Family of 4	Income of $67,050	20% discount
	Income of $62,580	40% discount
	Income of $58,110	60% discount
	Income of $53,640	80% discount
	Income of $44,700	100% discount
Family of 5	Income of $78,510	20% discount
	Income of $73,276	40% discount
	Income of $68,042	60% discount
	Income of $62,808	80% discount
	Income of $52,340	100% discount
Family of 6	Income of $89,970	20% discount
	Income of $83,972	40% discount
	Income of $77,974	60% discount
	Income of $71,976	80% discount
	Income of $59,980	100% discount
Family of 7	Income of $101,430	20% discount
	Income of $94,668	40% discount
	Income of $87,906	60% discount
	Income of $81,144	80% discount
	Income of $67,620	100% discount
Family of 8	Income of $112,890	20% discount
	Income of $105,364	40% discount
	Income of $97,838	60% discount
	Income of $90,312	80% discount
	Income of $75,260	100% discount

If you have questions and/or think you may be eligible for **free** or **reduced** cost services, please complete the enclosed application or contact our PPM billing office at (802) 388-5673, or the Porter Hospital billing office at 388-4729. You may also visit us at our office on the grounds of Porter Hospital, 104 Porter Drive, Middlebury, VT 05753.
Porter Hospital/Porter Practice Management will make a conditional or final determination of your eligibility upon receipt of your application.

July, 2011

PORTER PRACTICE MANAGEMENT
PERSONAL FINANCIAL STATEMENT (please complete)

Name ______________________________ Account # ______________

Address ______________________________ Telephone (____) ____-________

Number of family Members Living Within Household ____________________

I hereby request Free Care Services for:

Myself_______ DOB:

My Spouse_____ Name: DOB:

(Please list the name and DOB for each additional child separately in this space):
1.
2.
3
4.

Other_______ Name/Relationship to you: DOB:

ASSETS		LIABILITIES	
Cash in Bank	$___________	Mortgage	$___________
Cash on Hand	$___________	Home Equity	$___________
Stocks & Bonds			
		Auto Loan	$___________
Other Investments		Credit Union	$___________
Auto- Make	$___________	Other Loans	$___________
Year	$___________	Credit Cards	$___________
Home- Rooms	___________		
Purchase Price	$___________		
Estimated Value	$___________	Medical Owed:	
Other Real Estate	$___________	Physician	$___________
Loan value-Life Insurance	$___________	Hospital	$___________
Furniture/Appliances	$___________		
Other Assets	$___________		
Total assets	$___________	Total Liabilities	$___________

HOUSEHOLD INCOME EARNED

Adjusted yearly Gross Income	$________________
Self-Employment	$________________
Social Security	$________________
Unemployment compensation	$________________
Workman's Compensation	$________________
VA Benefits	$________________
Alimony	$________________
Child Support	$________________
Pension(s)	$________________
Dividends, Rent, Royalties, etc	$________________
TOTAL INCOME	$________________

MONTHLY EXPENSES

Rent	$____________	Insurance	$____________
Food	$____________	Utilities	$____________
Fuel	$____________	Car Expenses	$____________
Clothing	$____________	Other:	$____________
		Total monthly expenses	$____________

MONTHLY GROSS INCOME

Your Employer__________________________ Gross Monthly $ __________________________

Spouse's ______________________________ Gross Monthly $ __________________________

I hereby acknowledge that the information given to Porter Hospital is correct, and is provided for the purpose of obtaining Reduced Fees or Free Care or to set up a monthly payment arrangement.

Signature: ____________________________________ Date: ____________________

Print Name: ____

PLEASE RETURN THIS COMPLETED APPLICATION, ALONG WITH PROOF OF INCOME, TO :

PORTER PRACTICE MANAGEMENT
104 PORTER DRIVE
MIDDLEBURY, VT 05753