

Mountain Valley Medical Clinic

P.O. Box 310

Londonderry, Vermont 05148

(802)824-6901

FINANCIAL ASSISTANCE PROGRAM

Mountain Valley Medical Clinic has financial assistance available to income-qualified patients to help with their medical bills.

If you are interested in applying for assistance, please complete and return the enclosed application with the information listed below.

- _____ A copy of your most current Federal Income Tax Return, including any supplementary schedules.
- _____ If you do not file taxes, your last four consecutive pay stubs from all employers.
- _____ A statement of unemployment benefits.
- _____ A statement of general assistance benefits from the Department of Social Welfare.
- _____ A statement of Social Security benefits.
- _____ Other _____.

If you are carrying an outstanding bill of 90 days or more, then arrangements must be made for payment before you will be offered financial assistance. You must make arrangements for financial aid within 60 days of the date of service. If this is not done within 60 days we will understand you are not interested in applying for assistance and are able to fulfill your financial obligation to MVMC. **Full payment of the balance due is then expected within thirty days.**

Once a patient is offered financial assistance and does not pay the bill in a timely manner, then the financial assistance is revoked and the amount of charity is reversed. The full amount of the original charge is sent to collections. If a bill is sent for collection the patient will be disqualified from the financial assistance program.

If a patient has any other insurance, including Medicaid, then it will be billed first.

If you have any questions, do not hesitate to call MVMC at (802)824-6901.

Thank you.

Cyndi MacDonald, R.N.

This application is intended to provide Mountain Valley Medical Center (MVMC) with information concerning your financial status. It will be used to determine eligibility for financial assistance.

PLEASE PRINT

PATIENT INFORMATION

Patient Name _____
Date of Birth: ____/____/____ Social Security Number ____ - ____ - ____
Current Address _____
Residency for the past (2) years _____
Number of persons living in the household _____
Names of all dependants _____
Home Telephone Number _____

EMPLOYMENT

Presently employed? _____ Date Last Worked _____
Employer Name _____
Employer Address _____
Employer Telephone _____ Length of Employment _____
Spouse Employed? _____ Date Last Worked _____
Employer Name _____
Employer Address _____
Employer Telephone _____ Length of Employment _____

INCOME

Total Monthly Gross Income _____ Unemployment Income _____
State Aid Income _____ Other _____
Name of Health Insurance _____

I certify that the information I have provided to determine eligibility is true and correct, and I hereby authorize Mountain Valley Medical Clinic to verify my past and present employment and earning records. The information obtained is only to be used in the processing of my application for financial assistance.

Signature of applicant _____

For Office Use Only: Received: _____
Eligibility: _____ % Discount: _____
Denied: _____ Reason: _____
Effective Date: _____ Initials and Today's Date: _____

APPLICATION FOR REDUCED RATE SERVICES

MOUNTAIN VALLEY MEDICAL CLINIC

38 Vermont Route 11
P.O. Box 310
Londonderry, Vermont 05148

INDIVIDUAL NOTICE

Mountain Valley Medical Clinic provides a reasonable amount of services at a reduced rate to those who live in our catchment area and cannot afford to pay for care. The catchment area includes Londonderry, Weston, Peru, Landgrove, Windham, Winhall (Bondville) and Jamaica (Rawsonville). These services included all services provided at MVMC except for the reading fee for x-rays (done and billed by outside Radiologist), send-out laboratory studies and Bone Densitometry. To be eligible for reduced rate care, your family income and size should be at or below the following levels:

To figure out what percentage off full charge you are eligible for, please refer to the following chart:

Family Size	100%	75%	50%	25%	FULL PAY
1	<\$9,800	\$ 9,800-12,250	\$12,251-14,700	\$14,701-19,600	> \$19,600
2	<\$13,200	\$13,201-16,500	\$16,501-19,800	\$19,801-26,400	> \$26,400
3	<\$16,600	\$16,601-20,750	\$20,751-24,900	\$24,901-33,200	> \$33,200
4	<\$20,000	\$20,001-25,000	\$25,001-30,000	\$30,001-40,000	> \$40,000
5	<\$23,400	\$23,401-29,250	\$29,251-35,100	\$35,101-46,800	> \$46,800
6	<\$26,800	\$26,801-33,500	\$33,501-40,200	\$40,201-53,600	> \$53,600
7	<\$30,200	\$30,201-37,750	\$37,751-45,300	\$45,301-60,400	> \$60,400
8	<\$33,600	\$33,601-42,000	\$42,001-50,400	\$50,401-67,200	> \$67,200

We will notify you in writing of our determination.

Please note that those qualifying for 100% reduced care will still be subject to a nominal \$10 copay at the time of each provider visit. All approved reduced rates are good for one year unless otherwise specified.