Dartmouth Health

Southwestern Vermont Medical Center

Financial Assistance Application

Southwestern Vermont Medical Center is committed to giving high quality care no matter your insurance or financial situation by making financial assistance available to our patients. The determination in establishing financial assistance is based on the most recently published federal poverty guidelines. The financial assistance program covers emergency and medically necessary medical services.

Please complete the attached form, sign it and return all the necessary information needed. All applications must have proof of income attached. Your application will be reviewed to determine eligibility and you will be notified of our determination in a timely manner. All applications for financial assistance without the necessary documentation for support will be returned to the patient.

Please include all applicable documentation from the list below:

1. Copy of prior year Federal Tax Return*
2. Copy of prior year State Tax Return
3. Copy of Business Tax Return (If applicable)
4. Copies of 2 most recent pay stubs or written verification from employer
5. 2 Months of bank statements including checking, savings and money market
6. Copy of Social Security income statement
7. Copy of pension benefit statement
8. Copy of unemployment benefit statement

*If you are unable to provide current year tax return or if tax return does not reflect current income, you may submit alternative documents such as W-2, pay stubs or statement from employer.

Effective *2/1/2025*, the income requirements are:

Family Size	<=250% FPL	251%-300%	300%-400% FPL
	100% Discount	75% Discount	70% Discount
1 Person	$39,125	$46,950	$62,600
2 People	$52,875	$63,450	$84,600
3 People	$66,625	$79,950	$106,600
4 People	$80,375	$96,450	$128,600
5 People	$94,125	$112,950	$150,600
6 People	$107,875	$129,450	$172,600
7 People	$121,625	$145,950	$194,600
8 People	$135,375	$162,450	$216,600

For the purposes of determining eligibility for financial assistance, liquid assets in excess of 400% of the federal poverty level will be considered. Examples of liquid assets include cash, savings, checking CD, stocks/bonds, secondary homes. Patient's primary residence, automobiles, retirement accounts and pension plans are not considered in determining eligibility.

Please return application and proof of income to: **SVMC**
100 Hospital Drive, Box 52
Bennington, VT 05201

You can either bring in our forms in person or mail them to the address above. Should you require any help in completing these forms, please call (802) 447-4500. A Patient Financial Advisor will be glad to assist you.

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Applicant's Information

First Name	Last Name	Social Security Number	Date of Birth

Address	City	State	Zip Code

Phone Number	Employer	Occupation

Household Information

Please list dependents who live in your household. Household is defined as all dependents who live in the same residence as the patient and/or guarantor. A patient's household includes the patient, spouse, dependent children and unmarried couples with a mutual child living together. Dependents listed should be reflected on your federal income tax returns.

Name	Relationship	Date of Birth	SSN#	Occupation

Household Income

Income	Person 1	Person 2	Person 3
Wages			
Farm or Self-Employment			
Social Security			
Unemployment			
Alimony from settlement before 2019			
Income from Pensions			
Income from Dividends/Interest/Rent			

Liquid Assets

Liquid Assets	Person 1	Person 2	Person 3
Checking Account			
Savings Account			
CD Account			
Money Market			
Other:			

Are you covered under any health insurance policy? ☐Yes ☐No If yes, list insurance(s) _____

Have you applied for state health insurance? ☐Yes ☐No If yes, what is the status of the application? _____

Did you file previous year taxes? ☐Yes ☐No If No, please indicate why you did not file taxes: _____

I hereby request that Southwestern Vermont Medical Center make a determination of my eligibility for financial assistance at Southwestern Vermont Medical Center. I verify that all information I have provided is accurate and complete. I understand that the information that I submit concerning my annual income and family size is subject to verification and if it is determined to be false, such a determination will result in a denial of my application for financial assistance

Signature:_____ Date: _____