Financial Assistance Program

Thank you for choosing Rutland Regional Medical Center as your healthcare provider. Our Financial Assistance Program allows us to provide quality healthcare to patients regardless of their ability to pay and to offer a discount on billed charges for those who can pay a portion of the costs of their emergent and medically necessary care.

If approved, a patient's obligation to Rutland Regional may be reduced or eliminated for a period, as specified. Financial Assistance is also available for balances after insurance if your insurance guidelines have been followed and requirements are met.

The following criteria must be met to be eligible for financial assistance from Rutland Regional:

- Income of the household members (as reported on your federal income tax return) must be within the following guidelines:

2024 Federal Poverty Guidelines for Financial Assistance Program (FAP)				
Persons in Household	**Federal Poverty Level (FPL)**	**Up to 300% FPL**	**301-400% FPL**	**401-500% FPL**
1	$15,060	$45,180	$60,240	$75,300
2	$20,440	$61,320	$81,760	$102,200
3	$25,820	$77,460	$103,280	$129,100
4	$31,200	$93,600	$124,800	$156,000
5	$36,580	$109,740	$146,320	$182,900
6	$41,960	$125,880	$167,840	$209,800
7	$47,340	$142,020	$189,360	$236,700
8	$52,720	$158,160	$210,880	$263,600
Allowed Discount		**100%**	**75%**	**50%**
Amount Owed		**0%**	**25%**	**50%**
Note: Applicants may be denied when liquid assets are more than 400% of the FPL				

- Catastrophic assistance is applicable when Rutland Regional medical expenses exceed 20% of the household income.
- Please send completed application with supporting documents to, or contact us with questions:

» **Mail:**
Rutland Regional Medical Center
Attn: Financial Counselors
160 Allen Street
Rutland, VT 05701

» **Phone:** 802.747.1648

» **Fax:** 802.747.6272

» **Email:** Patientaccounts@rrmc.org

Document Checklist

Required Documents

We need proof of your income and liquid assets. Please provide the following:

- ☐ **Income:** Complete copy of your most recent Federal Income Tax Return and all schedules and forms, (e.g. 1040, 1099 etc.) ***Note:*** If you do not file taxes or this does not reflect your current income, please see alternative documentation options below.
- ☐ **Liquid Assets:** Copy of two (2) most recent bank or other financial statements (e.g., savings, checking, money market, etc.) for each account held by a person applying on the application.

Additional Income Documentation

- ☐ **If employed:** Copies of two (2) most recent pay stubs from all employers for each person applying on the application. If not available, please supply a written statement from employer with income information.
- ☐ **If unemployed:** Copy of unemployment benefits statement if applicable (e.g., check, bank statement, online, etc.).
- ☐ **If self-employed:** Profit and Loss statement for the last 3 months.
- ☐ **If you own a rental property:** Rental Income – Copy of current Schedule E of IRS form.
- ☐ **If you receive social security disability benefits:** Copy of disability compensation benefit statement/ award letter or check, bank statement, online, etc.
- ☐ **If you receive social security, pension, retirement income:** Copy of your award letter, check stub, bank statement, etc. ***Note:*** Supplemental Security Income does not need to be provided.
- ☐ **Other types of income:** If you receive income not listed here, please contact Financial Counseling at 802.747.1648 or email patientaccounts@rrmc.org to determine needed documentation.

Financial Assistance Program – Application

Applicant's Information

Last Name	First Name	Middle Initial	Date of Birth	Social Security Number

Address	City	State	Zip Code	Home Phone Number

Household Information

Please list all dependents who live in your household. Household is defined as self, spouse/domestic partner, and all tax dependents. If you do not file taxes, please list the people who would be your tax dependents if you did file.

Full Name	Last 4 Digits of SSN	Relation to You	Employed? Yes/No
		Self	

If you need more space, list additional people on a separate piece of paper and attach to this application.

Additional Information

Are you covered under any health insurance policy? ☐ Yes ☐ No

If yes, list insurance(s):

Ins. Co. Name: _____ ID #_____

Ins. Co. Name: _____ ID #_____

Expenses & Liabilities

All fields must be filled out. Enter N/A or $0 if not applicable.

Living Expenses		
	Monthly Expense	Comments
Rent / Mortgage	$	
Utilities	$	
Health Insurance	$	
Child Care	$	
Other	$	
Auto (1)	$	
Auto (2)	$	
Hospital	$	
Private Doctor	$	
Credit Cards	$	
Other	$	

All fields must be filled out. Enter N/A or $0 if not applicable.

Monthly Income From	Person 1	Person 2	
Name of household member			Required documents
Gross Wages	$	$	2 most recent pay stubs
Business Income	$	$	3 months Profit & Loss statements
Social Security (does not include Supplemental Security Income – SSI)	$	$	Award letter, bank statement
Disability	$	$	Award letter, bank statement
Pension	$	$	Bank statement, pension check stub
Unemployment	$	$	Bank statement, online, etc.
Rental Income	$	$	Schedule E tax return, etc.
Other Income	$	$	Contact Financial Counseling
Total:	**$**	**$**	
Liquid Assets – Assets that can easily be converted into cash in a short amount of time			
Checking Account Balance	$	$	2 Consecutive bank statements
Savings	$	$	2 Consecutive bank statements
CD	$	$	2 Consecutive statements
Money Market	$	$	2 Consecutive statements
Other (please specify):	$	$	2 Consecutive bank statements
Total:	**$**	**$**	

You MUST sign and date the application and enter N/A if not applicable to you.

It is important that your application is complete, and that all necessary documentation is received. Applications received without supporting documents cannot be processed. All information you provide to us is confidential.

Please Read Carefully, Sign, and Date Application

I am requesting Financial Assistance from Rutland Regional Medical Center. I verify that all information I have provided is accurate and complete. Any incorrect, incomplete or false information provided may result in the cancellation of my application for Financial Assistance. Any information provided will be used solely to determine eligibility for the Financial Assistance Program. Information will remain confidential under the provisions of HIPAA federal regulations.

Signature _____ Date _____