



Springfield

Medical Care Systems, Inc.

Where People Come First

25 Ridgewood Road, P.O. Box 2003
Springfield, Vermont 05156
Phone: 802-885-7630 or 885-1616
Fax: 802-885-7396

Springfield Medical Care Systems (SMCS) is a non-profit healthcare corporation serving portions of Windsor and Windham Counties, Vermont and portions of Sullivan and Cheshire Counties, New Hampshire. SMCS operates the SMCS Community Health Center (CHC) network which provides primary and preventative care at community health center locations dispersed throughout the service area. A subsidiary of SMCS, Springfield Hospital, (with campuses in Springfield and Bellows Falls, VT) provides acute care services, including mental health, and also operates specialty physician practices.

SMCS is committed to meeting the needs of the residents of its defined service area by offering a sliding fee scale to all income-eligible uninsured or underinsured patients based on annual household income. Under no circumstances would SMCS withhold emergency medical care to any individual.

SMCS offers a Financial Assistance Program (FAP) to reduce the burden of medical expenses for patients who demonstrate financial need. The FAP provides discounted care based upon family income in relation to Federal Poverty Level guidelines.

There is no residency requirement for services provided by the SMCS CHC network. In order to be eligible for financial assistance for services provided by Springfield Hospital, the patient/guarantor must be a resident of the State of Vermont or Sullivan or Cheshire Counties, New Hampshire. An applicant residing outside Vermont or the indicated New Hampshire counties that has been deemed eligible for assistance for CHC services may also be deemed eligible for Springfield Hospital assistance.

If you need help completing the SMCS FAP application or your application for Vermont/NH Medicaid included in this packet, please call 802-885-7630 or 802-885-1616. A face-to-face appointment can greatly expedite the eligibility determination process.

This financial assistance application is for services provided and billed by Springfield Medical Care Systems. If you are declared eligible for financial assistance, your eligibility will be in effect for one year. It is your responsibility to notify Springfield Medical Care Systems of any bills that you receive from the date that you made application and the date you are notified of approval.

Please note:

- For your application to be considered for financial aid, you must submit all documentation requested within 30 (thirty) days of the receipt of the application.
- You must sign your application.
- Correctly filling out the application is not a guarantee of financial aid.
- SMCS will not grant financial aid for any elective procedures for any patient account.

If you wish to apply for our financial assistance program, please complete and return the enclosed application.

Please attach all applicable requested verification of income from the list below for all members in your household who share expenses and have income.

- A complete copy of your most recent income tax return.
- If you own a business, business taxes and the last three consecutive months ledgers. Please be sure to include a copy of your schedule C.
- Your last four (4) consecutive pay stubs from all employers.
- A statement of unemployment benefits for all household members receiving benefits.
- A statement of any cash assistance from the state in which you live.
- A statement of Social Security benefits for all household members receiving benefits.
- Springfield Medical Care System requires that you apply for Vermont or NH Medicaid. Please include a copy of your Medicaid denial if you have already applied and been denied.



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FINANCIAL ASSISTANCE APPLICATION

This application is intended to provide Springfield Medical Care Systems with information concerning your financial status. It will be used to determine your eligibility for financial assistance.

Please print:

Patient Name _____ DOB _____

Social Security Number _____

Current Address _____

Home Phone _____ Cell _____ Work _____

Medical Insurance Carriers _____

Address _____

Subscribers Name _____ DOB _____

Policy Number _____ Group _____

Please list all names of household residents and dependents, including DOB:

If anyone listed below is also applying for financial assistance, please circle yes or no.

Name	Relationship	DOB	Applying
_____	_____	_____	Y / N
_____	_____	_____	Y / N
_____	_____	_____	Y / N
_____	_____	_____	Y / N
_____	_____	_____	Y / N
_____	_____	_____	Y / N

Number of persons living in household _____. Please provide all income documentation for anyone living in your household, sharing expenses, and who has income.

Do you receive Food Stamps: Yes____ No____ Housing Subsidy: Yes____ No____

Employment: Are you presently employed? Yes____ No____ Date Last Worked _____

Income: Total Monthly Gross Income _____ Unemployment _____

Farm income or self employment _____ Public Assistance/Veterans _____

Social Security (SS) _____ Spouse SS _____ Children SS _____

Alimony _____ Child Support _____ Pensions _____

Income from dividends, interest, rent, or other income _____

Checking account balance \$ _____ Savings \$ _____

Please attach all income verification and return your completed application to:

Springfield Medical Care Systems
Attn: Patient Financial Services
P. O. Box 2003
Springfield, VT 05156
Phone: 802-885-7630
Fax: 802-885-7396

Valley Health Connections
268 River Street
Springfield, VT 05156
Phone: 802-885-1616
Fax: 802-885-3324

We will make every attempt to provide you written notification of our decision within 60 days of submission of your completed application. Your accounts will be placed in pending status until our decision has been finalized.

To better assist you, please circle any of the following physicians/providers from whom you or other household members included in your application have received services.

Charlestown Family Medicine
Daniel Caloras, MD
Jeffrey Bell, MD
Frances Uptegrove, PA-C
Brooke Pringle, PA-C

Chester Family Medicine
Robert Schwartz, MD

Family Medicine Associates
Barbara Dalton, MD
Yolanda Lawrence, MD
Jackie Roy, NP
Joni Foster-Robison, NP
Bridget Fillo, NP

Ludlow Health Center
Cecil Beehler, MD
Forrest E. Williams, PA-C
Justin Sacripante, PA-C
Patricia Brown, FNP

Pediatric Network
Stephen Reville, MD
Amy Ferguson, MD
Roger Owen, MD

Ridgewood Associates In Internal Medicine
Mark C. Hamilton, MD
Ellen Brown, MD
Ruth F. Cody, PA-C
Anthony P. Petrillo, PA-C
Ellen R. Pinter, PA-C
Gordon Black, FNP-BC, APRN

Rockingham Medical Group
Gary Clay, MD
John Leppman, MD
Eliot Hall, MD
Linda Thomson, Ph.D., MSN, APRN
Jody Houghton, PA-C
Brooke Pringle, PA-C
Cynthia Chan, PA-C

Sleep Medicine Clinic
Bradley Reynolds, MD

Springfield Internal Medicine
John Hughes, MD

Women's Health Center of Springfield
Anne Stohrer, MD
William Ellis, MD
Simon Solano, MD

The Windham Center
Ray C. Abney, MD
William Grass, MD
Jean Etter, LICSW
John Herscher, LICSW
Janet Farley, LICSW
Sandra Zawalick, LICSW
Carol Hoyt, LICMHC
Sandra Cotter, LADAC
Carl McNeeley, NP
Mary Ann Abney, NP
Therese Zocchi, MA

General Surgery (non-elective)
Federico Fiallos, MD
George Kopidakis, MD
Gerald Drabyn, MD

Springfield Urology
Marie-Claude Bettencourt, MD

CT Valley ENT
Christopher Ryder, MD

CT Valley Orthopaedics & Sports Medicine
David L. Muller, MD
Carl Gutierrez, MD
Timothy J. Mello, PA-C

Springfield Anesthesia
Anthony Fazzino, MD
Sara Schaefer, MD

Emergency Room Only

Springfield Hospitalist Service

Radiology Services at Springfield Hospital

I certify that the information I have provided to determine eligibility is true and correct. I hereby authorize Springfield Medical Care Systems to verify my past and present employment and earnings records. The information obtained is to be used in processing my application for financial assistance.

Signature of Applicant

Date