The Vermont Eye Surgery & Laser Center, LLC

Charity Policy and Requirements for Free Care

Vermont Eye Surgery and Laser Center provides financial assistance programs to its patients consistent with its mission and values. These programs reflect our commitment to provide financial assistance to patients who cannot pay for parts or all of the care received.

Financial assistance is available at **no charge** for qualifying patients at or below the Health and Human Services Poverty Guidelines. Qualifying Charity Patients may receive any services provided by the center except for elective services. Patients who are between the Poverty Line and 200% of the HSS Guidelines may receive any services provided by the center except for elective services at **half charge.** Patients requesting financial assistance are required to complete an application and provide various financial information; including proof of income. Patients will be notified in writing as to their approval status within fifteen (15) working days of receipt of a completed application. Patients qualifying for half charge must make payment at least two (2) days prior to services being rendered. It is expected that as part of the financial assistance approval process, patients will cooperate in applying for Medicaid or other health and welfare programs as appropriate.

The center's financial assistance programs include assistance to legal residents of the State of Vermont and the United States of America.

Anyone seeking uncompensated services may request them by completing an application at:

The Vermont Eye Surgery and Laser Center

1100 Hinesburg Road Suite 101, South Burlington, Vermont. 05403.

Monday-Thursday (except holidays) from 8:00 AM to 4:00 PM.

Please call: 802 861-3554 for additional information.

Applicants need to complete the Financial Hardship application and provide the following documents. Eligibility will be determined as follows:

1. Free Care Request and Application

2. Personal Financial Statement:
    a. Applicant must prove through financial disclosure that their income or available money does not allow payment of medical bills and that they are not covered by any medical insurance plan.
    b. Total income is based on how the applicant files their taxes (single, married or head of household).

3. Provide written proof of total income. Ideally this will be for the past twelve (12) months (from the date of application back twelve months).

4. Elective outpatient procedures are not considered covered services. Admissions must be medically necessary services, with determination made by The Vermont Eye Surgery and Laser Center of Vermont Utilization Department.

5. Free Care Income Guidelines are taken directly from the US Health and Human Services 2017 Poverty Guidelines on-line at: https://aspe.hhs.gov/poverty-guidelines
    a. A copy of the current HSS Poverty Guidelines is available at The Eye Surgery Center, 1100 Hinesburg Rd. Suite 101, So. Burlington, Vt. – during normal business hours.

6. Applicants whose income falls within the Free Care Income Guidelines will be eligible for consideration.

7. The Vermont Eye Surgery & Laser Center reserves the right to accept patients outside of these guidelines who have compelling and extenuating circumstances. Such as: Patients who are immediate family members of a Vermont Fallen Hero (as defined by a military member or first responder who has lost their life in the service of our state and country), recent immigrants to Vermont and the United States from war torn or areas of strife who are legal residents of Vermont and the United States and Vermonters who have suffered a natural disaster or personal catastrophe may apply for special consideration.

8. Final selection is at the sole digression of the Patient Financial Manager based on the applicant's merit and the center's remaining and available resources for Charitable Care and once a decision has been rendered it in final.

Once the completed documents are submitted, the Patient Financial Manager will review to make a determination of eligibility. The Manager of Financial Accounts then mails a written determination to the applicant.

EYE SURGERY AND LASER CENTER OF VERMONT

APPLICATION FOR CHARITY FREE CARE PROGRAM

Patient Name:_____ Social Security No:

Address: State: Zip Code

Date Of Birth: _____ Phone (home): _____ (work)

PLEASE LIST ALL MEMBERS OF YOUR HOUSEHOLD AND COMPLETE ALL FIELDS

Name	Relationship to Patient	Date of Birth	Social Security No	Employer

INSURANCE

Name: _____ _____ _____(Copy of Card)

Address of Insurance:

Subscriber: _____ Group# Certificate #

WHAT IS YOUR MONTHLY HOUSEHOLD INCOME?

SOURCE OF INCOME MONTHLY GROSS AMOUNTS

	Applicant	Co-Applicant	Other
Wages/Salary/Tips			
Social Security Benefits_____			
Workers Compensation			
Unemployment Benefits_____			
Child Support			
Pension			
Public Assistance (Welfare)/Food Stamps/Fuel Assistance			
Other Income			
Rental Income			
Interest Income			

TOTAL MONTHLY HOUSEHOLD INCOME $__

(PROOF OF INCOME REQUIRED. PLEASE FURNISH OFFICE WITH FEDERAL TAX RETURN AND (3) RECENT PAYSTUBS FROM ALL WORKING MEMBERS OF THE HOUSEHOLD

WHAT IS YOUR MONTHLY HOUSEHOLD EXPENSES?

	MONTHLY AMOUNT	BALANCE		MONTHLY AMOUNT	BALANCE
1st Mortgage			Property Taxes		
2nd Mortgage			Other Taxes		
Rent					
Utilities			Child Care		
Food			Auto Loan		
Personal Loan			Auto Insurance		
Other Insurance			Child Support		
Credit Card			Credit Card		
Credit Card			Doctors Owed		
Other Facility Owed					

TOTAL MONTHLY HOUSEHOLD EXPENSES $

If your household had no income or your expenses exceeded your income, please explain on a separate piece of paper how your obligations are being met and attach to this application.

HOUSEHOLD ASSETS

Property Owned
Stocks & Bonds — Interest
CD (Certificate of Deposit) — IRA
Investment Income — Trust Accounts

Checking Account Balance $ — Account #
Name of Bank
Address

Savings Account Balance $ — Account #
Name of Bank
Address

I affirm that all information provided above is accurate to the best of my knowledge. I authorize Eye Surgery and Laser Center of Vermont to verify employment, income, expense and asset information as needed to determine eligibility. I understand that this program is the payor of last resort and therefore have made applications to any other insurance or federal and/or state assistance programs which may help with my medical bills for prior of future services.

SIGNATURE OF APPLICANT — DATE

SIGNATURE OF CO APPLICANT — DATE

For Office Staff Use Only.

A. Federal Poverty Income Guideline for _____ household = $

B. Household Monthly Income ($) X 12 = $

C. Line A minus Line B = $ (If Line B is greater than Line A, then household is over income for CFC program per current Federal Poverty Income Guidelines) Outcome: CFC is approved.

CFC is denied. CFC is pending for additional information:

The Vermont Eye Surgery & Laser Center, LLC

Financial Hardship Agreement

I _____ am making this request to The Vermont Eye Surgery Center to pay out-of-pocket medical expenses for a non-elective medical necessary surgery.

The reason for this request is: (please circle one)

- I do not have health insurance
- I am currently in a bankruptcy status
- I have had a catastrophic personal situation
- Other: _____

_____

_____

I understand that The Vermont Eye Surgery Center's 'self-pay' option is part of their Financial Assistance Program and it is a last resort request. Therefore I will be applying to other federal and/or state assistance programs which may help me with my future medical bills.

Signature of the Applicant: _____ Date: _____

Signature of the Witness: _____ Date: _____