Free Care Program

The Rutland Regional Medical Center has financial assistance available to help with medical bills for patients who demonstrate financial need.

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

- ☐ If you own a business, business taxes and the last three consecutive months ledgers.
- ☐ A copy of your_____ Federal Income Tax Return, including any supplementary schedules. W2s are not acceptable.
- ☐ 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 applying between July 1st and December 31st, we require that you submit both your Federal Income Tax Returns and your last four pay stubs.

If we do not receive this information within thirty days, we will understand you are not interested in applying for assistance and are able to fulfill your financial obligation to the Medical Center. Full payment of the balance is then due within thirty days.

If you have any questions, do not hesitate to call the Medical Center at 802.747.1751, or toll free at 1.877.233.4561. Thank you.

Sincerely,
RRMC Patient Accounting Department

160 Allen Street, Rutland, VT 05701 • 802.775.7111 • www.rrmc.org

Free Care Program Application

Date__________ MR#__________

This application is intended to provide the Medical Center 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__________

Telephone__________

Number of persons living in the household__________ US Citizen YES________ NO________

Names and social security numbers for all dependants living in the household__________

____

Do you receive: Food Stamps YES___ NO___ Housing Subsidy YES___ NO___ ANFC YES___ NO___ SSI YES___ NO___

EMPLOYMENT

Presently Employed? NO_______ Date Last Worked__________

YES______ Employer Name__________

Employer Address__________

Employer Telephone__________ Length of Employment__________

Spouse Employed? NO_________ Date Last Worked__________

YES________ Employer Name__________

Employer Address__________

Employer Telephone__________ Length of Employment__________

INCOME

Total Monthly Gross Income __________ Unemployment Income__________

State Aid Income__________ Other__________

Name/Address of Health Insurance__________

Subscriber Name__________ Policy Number__________

I certify that the information I have provided to determine eligibility is true and correct, and I hereby authorize Rutland Regional Health Services to verify my past and present employment and earnings records. The information obtained is only to be used in the processing of my application for financial assistance.

Signature of applicant __________

Rutland Regional Medical Center

An Affiliate of Rutland Regional Health Services

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Free Care Program Application

ASSETS (items you own)	Name of Bank	Balance
Checking		
Savings		
Stocks/Bonds		
Investments		
Other(specify)		
TOTAL		

DEBTS (living expenses)	Creditor Name	Monthly Payment	No. Months Past Due
Rent			
Mortgage(s)			
Mortgage Insurance			
REAL ESTATE TAXES			
Auto Loan			
Alimony			
Spousal Support			
Child Support			
Electric			
Fuel			
Medical (other than RRMC)			
Physicians			
Telephone			
Credit Card			
Credit Card			
Credit Card			
Other			
Other			
TOTAL			