Brattleboro Retreat
COMPREHENSIVE MENTAL HEALTH SERVICES SINCE 1834

FINANCIAL ASSISTANCE APPLICATION AND INSTRUCTIONS

Brattleboro Retreat 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.

This completed application is needed to evaluate and validate your eligibility in the Brattleboro Retreat financial assistance program.

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.

The Brattleboro Retreat offers two types of financial assistance for medical care: general and catastrophic financial assistance.

- **General financial assistance:** household income must be less than or equal to 500% of the current year's Federal Poverty Level (FPL)
- **Catastrophic financial assistance:** household income must be less than or equal to 600% of the current year's Federal Poverty Level (FPL) and if total financial responsibility for Brattleboro Retreat-related medical services are equal to or greater than 20% of the household income.

There is no residency requirement to be eligible for Brattleboro Retreat's Financial Assistance Program

	Federal Poverty Guidelines (FPL) for Financial Assistance Program (FAP)		
	≤ 300% FPL	300 - 400% FPL	401 - 500% FPL
Allowed Discount	100%	75%	50%
Amount Owed	0%	25%	50%

For Vermont residents whose household income is less than 138% FPL, the patient is required to investigate and apply for any available government assistance programs, such as Green Mountain Care (Medicaid), or Vermont Health Connect, before applying for the Brattleboro Retreat's Financial Assistance Program. If you need help applying for government assistance programs, our Financial Counselor can help. Undocumented persons are not required to apply for Medicaid in order to qualify for financial assistance.

For reference to the percentages referenced in this document, please see chart below:

2025 Federal Poverty Guidelines for 48 contiguous states and DC				
Persons in family / household	Federal Poverty Level	138% of FPL	300% - 400% of FPL	400-500% of FPL
1	$15,650	$21,597.00	$46,950-63449	$63,450-78250
2	$21,150	$29,187.00	$63,450-79949	$79,950-105,750
3	$26,650	$36,777.00	$79,950-96449	$96,450-133,250
4	$32,150	$44,367.00	$96,450 -112,949	$112,950 -160,750
5	$37,650	$51,957.00	$112,950-129,449	$129,450-160,750
6	$43,150	$59,547.00	$129,450-145,949	$145,950-188,250
7	$48,650	$67,137.00	$145,950-162,449	$162,450-215,750
8	$54,150	$74,727.00	$162,450-216,600	$216-600-270,750
9+	Add $5,500 per additional person.			

1. APPLICANT'S INFORMATION

Please complete this section about the applicant. The applicant is the patient or person seeking care.

Last Name	**First Name and Middle Initial**	**Date of Birth**	**Social Security Number (if known)**
Street Address	**City/Town**	**State**	**Zip**
Mailing Address (if different)	**City/Town**	**State**	**Zip**
Home Phone	**Cell Phone**	**Email address**	

2. 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. 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 of Family Member	Relationship	Date of Birth
	SELF	

3. HOUSEHOLD INCOME AND ASSETS

Please complete this section about earned income for applicant and each household member listed in Section 2 who receives income from employment or other income sources. Please list gross income, which is income before taxes and deductions. Please attach documentation of income reported, if not reflected in other documents provided. This could include, for example, pay stubs, bank statements, award letters from social security, etc. Liquid assets refers to assets that can be converted into cash in a short period of time.

Monthly Income From	**Applicant 1**	**Other Household Member (1)**	**Other Household Member (2)**
Name of Household Member:			
Gross (Before Tax) Wages	$	$	$
Business of Self-Employment Income	$	$	$
Social Security Income	$	$	$
Alimony from settlement before 2019	$	$	$
Pension / Annuity Income	$	$	$
Unemployment Income	$	$	$
Rental Income	$	$	**$**
TOTAL:	**$**	**$**	**$**
LIQUID ASSETS			
	Applicant 1	**Other Household Member (1)**	**Other Household Member (2)**
Checking Account Balance	$	$	$
Savings	$	$	$
CD Account Balance	$	$	$
Money Market	$	$	$

Other:	$	$	$
TOTAL:	**$**	**$**	**$**

4. EXPENSES AND LIABILITIES

Please complete this section about expenses and liabilities for applicant and all household members listed in Section 2.

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

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

ADDITIONAL INFORMATION:

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

5. AUTHORIZATION

Please read this section carefully then sign and date.

I am requesting Financial Assistance from the Brattleboro Retreat. I verify that All information I have provided in this application is true and accurate to the best of my knowledge. Any incorrect, incomplete, or false information provided may result in cancellation of my application for Financial Assistance. I agree to provide additional documentation upon request. Any information provided will be used solely to determine eligibility for the Financial Assistance Program. **I understand that this confidential information** under the provisions of HIPAA federal regulations and cannot be disclosed to any party outside of the Brattleboro Retreat without my prior approval.

_____ _____

Signature of applicant **Date**

If signing on behalf of the applicant: All information in this application is true to the best of my knowledge.

_____ _____

Signature of authorized representative Date

_____ _____

Name of authorized representative Relationship to applicant

_____

Contact phone number