



Financial Assistance Application and Instructions

Brattleboro Retreat is committed to providing 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 and supporting documentation is required to evaluate your eligibility in the Brattlebor Retreat financial assistance program.

Please complete the attached form, sign it and date 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.

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 the 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

2026 Federal Poverty Guidelines for FAP

Persons in Household	Federal Poverty Level (FPL)	Income Up to 300% of FPL	Income Up to 400% of FPL	Income Up to 500% of FPL	Income Up to 600% of FPL
1	\$15,960	\$47,880	\$63,840	\$79,800	\$95,760
2	\$21,640	\$64,920	\$86,560	\$108,200	\$129,840
3	\$27,320	\$81,960	\$109,280	\$136,600	\$163,920
4	\$33,000	\$99,000	\$132,000	\$165,000	\$198,000
5	\$38,680	\$116,040	\$154,720	\$193,400	\$232,080
6	\$44,360	\$133,080	\$177,440	\$221,800	\$266,160
7	\$50,040	\$150,120	\$200,160	\$250,200	\$300,240
8	\$55,720	\$167,160	\$222,880	\$278,600	\$334,320
Allowed Discount		100%	75%	50%	variable
Amount Owed		\$0	25% of Balance Due	50% of Balance Due	20% of Household Income

For families/households with more than 8 persons, add \$5,680 for each additional person.

Note: Applicants will be denied financial assistance when liquid assets exceed the Medicare Low Beneficiary Limitation: Single \$9,950 Couple \$14,910

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

If you have questions regarding this application or need help to complete it, please contact:

Patient Financial Services
802-258-6745
Monday - Thursday: 8am to 5pm
Friday & Saturday: 8am to 3pm



Financial Assistance Application

Please complete this section about the applicant and household members. The applicant is either patient or the person who is financially responsible for the patient. Household members are 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 tax returns.

1. Applicant/Financial Guarantor Information

Name of Applicant	Date of Birth	Social Security #	Marital Status	Phone #
Address		City	State	Zip

2. Insurance Information

Are you covered under any health insurance policy? If yes, provide information below:	Yes	No
Insurance Company Name:	ID #:	
Insurance Company Name:	ID #:	
Have you applied for Medicaid?	Yes	No
Have you applied for coverage with your state's Health Exchange?	Yes	No

3. Household Members

List all family members who live in your household. Please include spouses, domestic partners, children under 21 living with the applicant (including stepchildren), full-time students under 24, children over 21 if claimed on taxes, or children (any age) who are permanently disabled. Domestic partner is defined as a person who lives with you in a committed/intimate relationship.

Household Member Name	Date of Birth	Social Security #	Relationship
(1)			
(2)			
(3)			
(4)			
(5)			

4. Monthly Household Expenses

Expenses are used to better understand your financial situation. Please attach an additional page if there is any other information about your current financial situation that you would like us to know.

Rent or Mortgage	\$:	Auto (1)	\$:
Utilities (water/electric)	\$:	Auto (2)	\$:
Health Insurance	\$:	Credit Cards	\$:
Alimony	\$:	Private Doctor	\$:
Child Support	\$:	Hospital	\$:
Child Care	\$:	Other	\$:



5. Monthly Household Income

Please complete this section about gross income for the applicant and each household member listed in section 3 who receives income from employment or other sources. Please use gross income, which is income before taxes and deductions. Please attach an additional page if you need to include additional household members.

Source of Income	Applicant	Household Member (1)	Household Member (2)
Gross (before taxes) Wages from Tax Return, W2, or Pay	\$:	\$:	\$:
Stubs Self-Employment Income from Profit & Loss Statement	\$:	\$:	\$:
Social Security from Award Letter or Last Bank Statement	\$:	\$:	\$:
Alimony (from settlement before 2019)	\$:	\$:	\$:
Pension/Retirement from Check Stub or Last Bank Statement	\$:	\$:	\$:
Unemployment from Unemployment Benefits Statement	\$:	\$:	\$:
Rental Income from Receipts	\$:	\$:	\$:
Other Income (please provide supporting documentation)	\$:	\$:	\$:
TOTAL:	\$:	\$:	\$:

6. Household Assets

Please complete this section about current assets for the applicant and each household member listed in section 3. Please attach an additional page if you need to include additional household members.

Source of Income	Applicant	Household Member (1)	Household Member (2)
Checking Account Balance	\$:	\$:	\$:
Savings Account Balance	\$:	\$:	\$:
CD Account Balance	\$:	\$:	\$:
Money Market Account Balance	\$:	\$:	\$:
Other: (please provide supporting documentation)	\$:	\$:	\$:
TOTAL:	\$:	\$:	\$:

7. Supporting Documentation Checklist

We require a minimum of two documents supporting your income and assets; however, please provide as many of the applicable documents listed below as possible to verify the information you have reported. Supporting documentation will enable us to process your application quickly and accurately. In most cases, we are unable to complete the process without applicable documentation. If you are unable to provide the requested documentation for any reason, please contact our financial counselors at 802-258-6745 or financialcounselor@brattlebororetreat.org to discuss other options.

Insurance Documents	Income Documents	Asset Documents
Copy of insurance cards	Most recent Federal Tax Return	Checking Account Bank Statement
Medicaid Denial letter	Profit and Loss Statement	Savings Account Bank Statement
State Health Exchange Denial letter	Two most recent pay stubs	CD Statement
	Social Security Benefit Verification letter	Money Market Statement
	W-2	
	Rental receipts	



8. Additional Information

Comments/additional information you would like to share:

9. Authorization

Please read this section carefully, then sign and date the application.

I am requesting financial assistance from Brattleboro Retreat. I verify that all information I have provided is accurate and complete 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 is confidential information** under the provisions of HIPAA federal regulations and cannot be disclosed to any party outside of Brattleboro Retreat without my prior approval.

Signature of Applicant/Financial Guarantor

Date

If signing on behalf of the applicant: I affirm that all information in this application is true to the best of my knowledge.

Signature of Authorized Representative

Date

Name of Authorized Representative (please print)

Relationship to applicant

Contact phone number

Please send the completed application with supporting documentation to one of the following:

Email: financialcounselor@brattlebororetreat.org

Fax: 802-258-3723

Mail: Brattleboro Retreat

Attn: Financial Counseling Department

PO Box 101

Brattleboro, Vermont 05302