

GOOD NEIGHBOR GRANT APPLICATION INSTRUCTIONS

Good Neighbor Grants are designed to make funds available to individuals residing in the Foundation Service Area who require assistance with their personal health care needs.

Foundation Service Area

The Foundation service area includes eight towns—Barnard, Bridgewater, Hartland, Killington, Plymouth, Pomfret, Reading, and Woodstock—as well as the Village of Quechee.

Use of Funds

The Foundation makes grants as needed for individual needs, such as eyeglasses, hearing aids, medical supplies, prescriptions, and medical and dental bills. Funds will be distributed to the agency or provider of the service, not to the individual applicant.

Supplementary Nature of Funds

To the extent possible, participation in the payment of costs by the applicant and service provider is required. The Foundation expects a substantial contribution toward the cost of the service by those with moderate incomes, absent special circumstances.

Eligibility

- Good Neighbor Grants will be accepted for consideration only after Medicaid, Dr. Dynasaur, or other programs have been sought out. Hospitals also offer programs which forgive or reduce monthly costs.
- Good Neighbor Grants are made based on financial need—both income and ability to pay. Please provide a copy of your past year's tax return. If you have special financial circumstances, please describe them briefly.
- Applicants must reside in the Foundation's service area.

Application Process

The applicant seeking funds will complete and submit the attached application to the Foundation. The Grants Committee will act on the request at its next monthly meeting. For requests of \$5,000 or more, the Board will act on the request at its next Board meeting. The applicant will be notified of the final decision on his/her application within seven (7) days of a decision.

Application Checklist:

- Applicant Information Page – signed
- Provider Information Page – signed
- Copy of the bill for service or service plan from the provider
- Copy of most recent income tax return

OTTAUQUECHEE HEALTH FOUNDATION

Good Neighbor Dental Grant Application (To be completed by client)

Date of Request: _____

Name of Applicant: _____ Date of Birth _____

Address: _____ Phone Number: _____

_____ Town Residence: _____
(where pay taxes)

Purpose of Request: _____

Amount Requested: \$ _____ Proposed payment by Applicant: \$ _____

Do you have any insurance or Medicare/Medicaid coverage that will cover part or all of this bill? ____ If yes, please indicate the amount of coverage: \$ _____

Place of Employment: _____

Monthly household wages: _____ Number of people in household: _____

Other sources of income (for example—child support, social security, welfare, alimony)

Source: _____ Monthly amount: \$ _____

If you think you have special financial circumstances, briefly describe them: _____

Please attach a copy of your most recent tax return.

RELEASE OF CONFIDENTIAL INFORMATION: I hereby authorize the agencies or persons listed below to release to the Ottauquechee Health Foundation for its use any information in my records maintained by any of the designated agencies or persons that is relevant or necessary for the purpose of providing assistance for my needs.

Name of person or agency involved with my care:

Phone Number

- | | |
|----------|-------|
| 1. _____ | _____ |
| 2. _____ | _____ |
| 3. _____ | _____ |

Applicant Signature: _____

OTTAUQUECHEE HEALTH FOUNDATION

Dental Provider Information To be completed by Dental Care Provider

Name of Dental Provider: _____ Degree: _____

Contact Name: _____

Provider Address: _____

Telephone: _____ Email: _____

Patient Name: _____

Description of service for which funds are needed:

(Attach separate sheet if necessary)

FINANCIAL INFORMATION

Total Bill for Service (attach copy of bill or service plan): \$ _____

Amount Covered by Insurance, if any \$ _____

Patient Contribution: \$ _____

Provider Contribution (15% of total suggested) \$ _____
(Please indicate if reduced rate or waiver of fees)

Total Request: \$ _____

Service Provider Signature: _____

Name (Printed): _____

FOUNDATION USE ONLY:

Committee Action Taken: _____ Date: _____

Board Action Taken: _____ Date: _____

Approval Signature: _____