

## **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 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: \_\_\_\_\_

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**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

## Provider Information To be completed by Provider

Name of 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 (10% 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: \_\_\_\_\_