OTTAUQUECHEE HEALTH FOUNDATION

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 nine towns—Barnard, Bridgewater, Hartland, Killington, Plymouth, Pomfret, Quechee, Reading, and Woodstock, Vermont.

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.
Funds are granted before treatment is received and paid after treatment is complete.
Approved grants must be used within sixty (60) days.

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 Medicare, Medicaid, Dr. Dinosaur, 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 and savings account statement.** If you have special financial circumstances, please describe them briefly.
- Applicants must reside in the Foundation's service area and provide a proof of residence.

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 and savings account statement

P.O. BOX 784, WOODSTOCK, VT 05091
802-457-4188 info@ohfvt.org www.ohfvt.org

GNG: APPLICATION INFORMATION (To be completed by client)

Name of Applicant: _____ Age: _____ Date of Request: _____

Date of Birth: _____ Town Residence: _____ (where you pay taxes)

Address: _____ Phone Number: _____

- Do you have Medicaid? □ Yes □ No If yes, is it: □ Vermont (VT) □ New Hampshire (NH)
- Do you have Private insurance? □ Yes □ No
- Are you employed? □ Yes □ No

  If yes: Place of Employment: _____ Salary/Hourly Rate: _____
- What is your monthly **household** income? $ _____
- Number of people in your household: _____
- Other sources of income (for example—child support, social security, welfare, alimony)

  Source: _____ Monthly amount: $_____
- Do you have a Savings Account? □Yes □ No **If yes**, what is the balance:$_____
- Housing (check all that apply): □ Own Home □ Rent Home □ Own second home □Other

  If Other Please Comment: _____

Is there anything else you think we should know when considering your application?

_____

_____

_____

Please attach a copy of your most recent tax return and savings account statement.

Applicant Signature: _____ Date: _____

Purpose of Request

Explanation: _____

_____

_____

_____

Continued …

OFFICE USE ONLY:

Amount Requested: $_____ Proposed Payment by Applicant: $_____

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GNG Release of Information

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. OHF Preferred Provider / Other	
2.	
3.	

☐ I give the Ottauquechee Health Foundation permission to send health information back to the above listed persons, providers and/or organizations.

Applicant Signature: _____ Date: _____