

**Financial Assistance Application**

**Before filling out your financial assistance application, read through this entire sheet**

Policy

Financial assistance is available to qualified persons receiving (1) emergency or (2) unscheduled, non-elective services and who are unable to pay for those services. Financial assistance is not to be considered a substitute for personal responsibility.

Application Requirements

* To become eligible for financial assistance as a medically indigent patient, the amount owed by the patient on the hospital bill after payment by third-party payers, *patient must be unable to pay the remaining bill.*
* Patient may qualify for a financial discount based on the patient’s total household annual gross income.
* All Financial Assistance applicants will be required to provide supporting income verification documents, as well as a complete Financial Assistance application.
* Patient has 6 months from date of service to apply for financial assistance.

Income Calculation

* For the purpose of determining financial eligibility for the financial assistance program, income includes all monies received before taxes from all sources, including but not limited to estate payments, current savings, net rental income, alimony, military family allotments, employee pensions or retirement plans, military retirement pay, veteran’s payments, net receipts from farm and on-farm self-employment, royalties, social security payments, railroad retirement, unemployment compensation, regular insurance or annuity payments, gambling/lottery winnings, interest, period receipts from estates or trusts, strike benefits from union funds, public assistance (including Supplemental Security income), private pensions and workers compensation.
* Income does not include Medicare, Medicaid, food stamps, heat-assistance funds, school lunches or housing assistance, the employer-paid or union-paid portion of health insurance or other employee fringe benefits, food or housing received in lieu of wages, gifts, loans, need based assistance from nonprofit organizations, college grants or loans, child support or foster-care payments, or disaster-relief assistance.

Items to Be Completed and Returned For Review of Financial Assistance

* A completed Financial Assistance Application.
* Federal Tax Returns – Provide Current and Prior Year Household Federal Tax Returns **if self-employed only**.
* Bank Accounts- Provide most recent 3 month copies of bank statements for all checking and savings accounts.
* Paycheck Stubs- Provide 4 of the most recent paycheck stubs.
* Proof of Rent and/or Mortgage.

**If you fail to return completed application along with requested documentation within 15 business days, the application will be denied. If you have questions please call 719-530-2475. Return application to HRRMC, PO Box 429, Salida, CO 81201.**

**2024 Financial Assistance Application**

Date of Application: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Responsible Party (if patient is a minor): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physical Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of family members living in the home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Spouse/Dependents)

Have you recently applied for HealthFirst (Medicaid) or other Medical Assistance Programs? Yes / No

**Income Verification (List all persons in the household who are employed)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *NAME* | *RELATIONSHIP TO PATIENT* | *EMPLOYER’S NAME & PHONE NUMBER* | *GROSS INCOME/MONTHLY* | *NET INCOME/MONTHLY* |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**OTHER INCOME VERIFICATION (List all persons in the household with other income)**

|  |  |  |
| --- | --- | --- |
| *Type* | *Recipient* | *Monthly Total* |
| Unemployment or Worker’s Comp |  |  |
| Social Security |  |  |
| Retirement or Pension Plan |  |  |
| Veterans Affairs Benefits |  |  |
| Commissions, Bonuses, Gifts, Tips |  |  |
| Alimony |  |  |
| Trust Accounts |  |  |
| Interest Income |  |  |

**RESOURCES (List all resources owned by members of the household)**

|  |  |  |  |
| --- | --- | --- | --- |
| *Resource* | *Bank Name* | *Owner* | *Available Balance* |
| Checking Account #1 |  |  |  |
| Checking Account #2 |  |  |  |
| Savings Account #1 |  |  |  |
| Savings Account #2 |  |  |  |

**PERSONAL PROPERTY**

|  |  |  |
| --- | --- | --- |
| *Description* | *Mortgage/Loan Amount* | *Monthly Payment* |
| Primary Residence |  |  |
| Rental Property |  |  |

|  |
| --- |
| I affirm that all of the information listed on this application is true and correct.  Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **The following information MUST be submitted:**  **\*\*What you pay in Rent and/or Mortgage**  **\*\*Four (4) Most recent Employer Paycheck Stubs**  **\*\*Three (3) months of Bank Statements for all accounts, must include the most recent month of Bank Statements**  **\*\***Current and Prior Year Household Federal Income Tax Returns **(for Self-employed only)**  **Return application to: HRRMC, PO Box 429, Salida, CO 81201**  *Note: Information obtained will be kept confidential and used only for Financial Assistance Determination.* |