Financial Assistance Application

Dear Patient,

Please find enclosed our Financial Assistance application. You must complete the entire application and return it with all of the required documentation (see below).
Please do not send original documents as they will not be returned.

The application process will be delayed or denied if all required documentation is not received. Financial Counselors will not process incomplete applications. Incomplete applications may render your account ineligible for financial assistance.

All information received will remain confidential.

You may receive statements and/or phone calls until your Financial Assistance Application is processed.

The basis of the Financial Assistance Program is the truthful and accurate provision and submission of financial information from the patient and/or responsible party (ies). Patients and/or responsible parties who intentionally misrepresent their household information will be automatically disqualified from any consideration whatsoever with regard to the program. Intentional misrepresentation determination is the sole right of PSMC.

Please answer all of the following questions:

1. Have you applied for Medicaid or CHP+? (yes or no)
2. When did you apply for Medicaid or CHP+? (date: _____)
3. What is the status of your Medicaid or CHP+ application? (approved, denied, pending)
4. Is anyone in the household pregnant? (yes or no)
5. Who in the household is pregnant? (name: _____)
6. Is anyone in the household disabled? (yes or no)
7. Who in the household is disabled? (name: _____)
8. Have disabled household members applied for disability benefits through Social Security? (yes or no)
9. Do household members over the age of 18 have the ability to work? (yes or no)
10. If they do not have the ability to work, why? (reason: _____
_____)
11. Is there third party healthcare coverage for any household members? (yes or no)
12. Specify type: (Medicare, Medicaid, CHP+, Insurance, Other)
13. Have any household members received CICP or charity care before? (yes or no)
14. If yes, list type. (name: _____)
15. Have you filed for bankruptcy? (yes or no)
16. Where and when did you file for bankruptcy? (when/where: _____)
17. Do you expect your income to change within the next year? (yes or no)
18. If so, what kind of change do you expect? (explain: _____
_____)

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The following documentation is required when applying for the Financial Assistance Program.

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INCOME:

- ✓ Most recent, complete Federal Income Tax Return and W-2 withholding statements
- ✓ One (1) month most recent, consecutive paycheck stubs OR a statement from the employer. The statement must include the employers name, address, phone number, tax ID number, hire date, rate of pay, and average hours worked per week
- ✓ Self-Employment: Last full month Profit and Loss Statement and three (3) consecutive months' gross deposits
- ✓ Unemployment income statements
- ✓ Disability compensation statements (ie. SSI, SSDI, other)
- ✓ Social Security Income (yearly benefits statements)
- ✓ Retirement and Pension benefit statements
- ✓ Public assistance notices such as Aid to the Needy and Disabled, TANF, LEAP, Food Stamps, WIC, etc
- ✓ Child Support Received
- ✓ Alimony Received
- ✓ If you have no income, and someone is supporting you, they must write a letter including their printed name, address, phone number and signature stating the type of support that is being provided
- ✓ Two (2) months most recent checking and savings statements

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Name_____ **Account Number** _____

Responsible Party		
Name	Marital Status	Social Security Number
Street Address, City, State, Zip	How long at this address	Home Number DOB
Employers Name and Address(If employed-how long)		Business Phone
Position Title	Monthly Income/Gross (list the source and amount of all income)	Length of Current Employment

Spouse		
Name	Marital Status	Social Security
Street Address, City, State, Zip	How long at this address	Home Number DOB
Employers Name and Address(If employed-how long)		Business Phone
Position Title	Monthly Income/Gross (list the source and amount of all income)	Length of Current Employment

Medicaid Coverage	
Have you applied for Medicaid coverage? Yes or No	
You must submit proof of denial for Medicaid coverage.	

List of Dependents living at home ***If additional space is required please use back of page**	
Total number of dependents	Do any other persons contribute financially to the family? Yes No Amount $
List the names of all persons in household	Date of birth Place of Birth

Income	**Value**
Salaries	$
Self-Employment	$
Unemployment	$
SSI	$
Retirement/Pensions	$
Social Security	$
Alimony	$
Child Support	$
Public Assistance	$

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Food Stamps	$
Other: Please describe	$

In completing this financial application, I hereby affirm that the above statements are correct and complete. I understand that if I have given false or misleading information, my application will be denied and any financial assistance I have been given will be retracted. I give my consent for further verification to Pagosa Springs Medical Center and/or its agents. I authorize Pagosa Springs Medical Center to obtain a credit report.

Signature_____

Printed Name_____Date _____

Relationship if other than patient_____

Notification of Approval or Denial

You will be sent a notification letter after your application has been reviewed and processed. If approved, your application will be valid for six (6) months from the date of the approval, unless your financial status changes (employment, insurance coverage, income, etc). You are required to immediately inform PSMC if your financial status changes.

If you have any questions or need assistance in completing this application **contact Patient Accounts at 970.585.1405**.

Return the application to:
Pagosa Springs Medical Center
Patient Financial Services
Pruitt Building
95 South Pagosa Blvd.
Pagosa Springs, CO 81147