Financial Assistance Application for Utah, Idaho and Nevada Facilities

Return Information to:
MAIL: Financial Assistance
PO Box 27327
Salt Lake City, Utah 84127
FAX: 385-831-2890
EMAIL: financial.assistance@r1rcm.com

Instructions for completing this form:

Please fill this form out completely and return all required documentation to the Intermountain facility where you had or plan to receive care or to one of the contact methods listed above for your application to be processed. You can also apply online through our Intermountain Health's Financial Assistance web page by clicking: ***Apply online****. Financial assistance will not be awarded to those who do not complete the application process.*

Please submit the following documentation:

1. **Financial Assistance application: completely filled out, signed, and dated.**
2. **Current Household income verification noted below.**

Account Number ________________ **Current Household Size** ______________ **Experiencing Homelessness?** Yes____ No_____ **Are you a Colorado Resident?** Yes____ No_____

First and Last Name_______________________________________ **Social Security Number**___________________ **Birth Date**______________________

Marital Status ____________ Email______________ Home Phone___________________Cell Phone _________________

Address____City______________________________State________Zip_____________

Employer Name ____Work Phone _____________________________

How long have you been employed by this employer? ______ Years ______ Months

Pay Frequency (please indicate) Weekly _______ Bi-Weekly ________ Twice a month ______ Monthly _______

How long have you lived at this address?________Years_______Months If ***less than three months***, please list address:

Address	City	State	Zip	From (Month/Year)	To (Month/Year)

Spouse Name ____ **Spouse Social Security Number**____________________ **Spouse Birth Date**_______________

Spouse Home Phone___________________________Spouse Cell Phone_______________________________________

Spouse Employer Name____Work Phone____________________________

How long have you been employed by this employer?_____Years_______Months

Pay Frequency (please indicate) Weekly_________ Bi-weekly____________Twice a month___________ Monthly___________

Additional Household Members/Dependents. Please add any additional dependents on a separate form.

First and Last Name	Birth Date	Social Security Number	Relationship

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Current Household Monthly Income

If you are unable to provide copies of the verified information; please provide 3 months bank statements with an explanation on the back of this form.

Type	Responsible Party Amount	Spouse Amount	Type of Income Verification Required
Employment Income (Gross)	$	$	*Copy of the most recent or last paystub or a letter(s) from your employer(s) stating gross earnings for the last or current month*
Self-Employment Income (Gross)	$	$	*Profit and Loss statement and/or ledgers for previous or current month. Current tax return if applicable.*

Pension, Retirement, Social Security Income	$	$	*Copy of current award letter(s), pension payments, payments from retirement accounts etc. Displaying monthly income.*
Unemployment, Disability Income, etc.	$	$	*Copy of current award letter(s)*
Other *(Please list source)*: ________________ ________________________________	$	$	*Ex: Tips, bonuses, and commissions*

Additional Questions: Answering these questions ensures your application processing isn't delayed for further information.	**Yes**	**No**
Do you or any members in your household receive public benefits? (i.e. Food Stamps, WIC or Free or Reduced Lunches)	☐	☐
Do you or any members in your household currently have health insurance?	☐ If yes, please list the name of your insurance carrier ____________ __________________________	☐
Have you or any of your current household members applied for Medicaid, Medicare, CHIP or CHP+? *If yes and denied, please provide denial letter*	☐ If yes, please list the date you applied__________________________	☐
Are any of your medical bills with our facilities related to an auto or work-related accident?	☐ If yes, please list the insurance company__________________________	☐
Are you enrolled in a Medical Healthshare or cost share plan?	☐ If yes, please provide an explanation of share (EOS)_ ______________________________	☐
Is anyone in your home currently pregnant?	☐ Who in the household is pregnant? ______________________________ Due Date? ____________________	☐
Colorado Residents Only:		
Do you provide 50% or more financial support to someone living outside your home that would like included in your household size calculation (individual may live out of state/country)?	☐	☐

We ask patients who apply for financial assistance to look for other funding also. Please check "Yes" or "No".

Are any of your medical bills due to an auto or work-related accident? ☐ Yes ☐ No If yes, list insurance company: _______________
Are you enrolled in a medical Healthshare plan? ☐ Yes ☐ No If yes, please provide explanation of share (EOS)
Does your employer reimburse you for any deductible or healthcare costs? ❑ Yes ❑ No

Have you applied for any other State assistance programs such as Crime Victims ❑ Yes ❑ No – move to box above

If needed, use the space below for further explanation of the reason you are requesting financial assistance. You may attach a separate sheet if more space is needed. Additional verification may be required.

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I hereby state that the information given herein is true and correct to the best of my knowledge. I understand if I mislead or provide false information to obtain financial assistance with Intermountain Health, the request will be denied and may impact future requests for assistance.
I understand that Intermountain Health requires verification of income before any determination is made.

Applicant Signature____ **Date**____________________

Checklist of all required information to complete application process:

- ❑ *Financial assistance application completely filled out, signed, and dated.*
- ❑ *Household income verification.*