Financial Assistance Application for Colorado and Montana Facilities

Return Information to:
MAIL: 500 El Dorado Blvd Ste 4300
Broomfield, Co 80021
FAX: 303-272-0931
EMAIL: Peaks_financialassistanceapps@imail.org

Instructions for completing this form:
Please fill this form out completely and return all required documentation to the Intermountain facility where you had care or to one of the contact methods listed above for your application to be processed. You can also apply online via MyChart. 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

Type	Patient Amount	Spouse Amount	Other Adult Household member/s	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 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/s)*:______________ ______________________	$	$	$	*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.