



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 ____	What state do you live in? _____
First and Last Name _____	Social Security Number _____	Birth Date _____	
Marital Status _____	Email _____	Phone # _____	
Address _____	City/County _____	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 previous 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. Include unborn child if applicable Please add any additional dependents on a separate form. (Household members must match the current household size question listed above)

First and Last Name	Birth Date	Social Security Number	Relationship

Current Household Monthly Gross Income

Type	Patient Amount	Spouse Amount	Other Adult Household members	Type of Income Verification Required
Employment Income (Gross)	\$	\$	\$	<i>Copy of the most recent or last paystub <u>or</u> a letter(s) from your employer(s) stating gross earnings for the last or current month</i>
Self-Employment Income (Gross)	\$	\$	\$	<i>Profit and loss statement or ledgers for previous or current month. Current tax return if applicable.</i>
Pension, Retirement, Social Security Income	\$	\$	\$	<i>Copy of the most <u>current</u> award letter(s), pension payments, payments from retirement accounts etc. Displaying monthly income.</i>
Unemployment, Disability Income, etc.	\$	\$	\$	<i>Copy of the most <u>current</u> award letter(s)</i>
Other (Please list source/s): _____ _____	\$	\$	\$	<i>Ex: Tips, bonuses, and commissions</i>

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)	☐	☐
Are you currently receiving or plan on receiving care at an Intermountain Health Cancer Center?	☐	☐
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+? <i>If yes and denied, please provide denial letter</i>	☐ 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 Health Share 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)?	☐	☐
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We ask patients who apply for financial assistance to look for other funding also. Please check “Yes” or “No”.

- Does your employer reimburse you for any deductible or healthcare costs? ____ Yes ____ No
- Have you applied for any state assistance programs such as Crime Victims? ____Yes ____ No

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.

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.



Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

We provide language assistance and appropriate auxiliary aids and services free of charge.
Please see staff for assistance.

Arabic	المساعدة على للحصول الفريق مراجعة يُرجى. مجاناً المناسبة الإضافية والخدمات والمساعدات اللغوية المساعدة نقدم	العربية
Chinese	我们免费提供语言协助和适当的辅助工具及服务。如需帮助，请咨询工作人员。	中文
French	Nous fournissons gratuitement une assistance linguistique et des aides et services auxiliaires appropriés. Consultez le personnel pour obtenir de l'aide.	français
German	Wir bieten sprachliche Unterstützung und angemessene zusätzliche Hilfen und Dienstleistungen kostenlos an. Bitte wenden Sie sich an unser Personal, um Unterstützung zu erhalten.	Deutsch
Hindi	हम भाषा सहायता और उपयुक्त सहायक उपकरण व सेवाएं ननि: शुल्क प्रदान करते हैं। सहायता के निम्न स्टाफ से नमि।	नहन्दी
Italian	Forniamo supporto linguistico, ausili e servizi pertinenti gratuiti. Per assistenza, rivolgersi al personale.	italiano
Japanese	言語サポート、および適切な補助やサービスを無償でお届けします。対応スタッフをご確認ください。	日本語
Korean	저희는 언어 지원 서비스와 적절한 보조 장비 및 서비스를 무료로 제공합니다. 도움이 필요하면 직원에게 문의하십시오.	한국어
Portuguese	Fornecemos assistência linguística e auxílios e serviços auxiliares apropriados gratuitamente. Consulte a equipe para obter assistência.	português
Russian	Мы предоставляем языковую поддержку, а также необходимые вспомогательные средства и услуги бесплатно. Обратитесь за помощью к персоналу.	Русский
Somali	Waxa aanu bixinaa kaalmo luuqadeed iyo kaalmada maqalka ee haboon iyo adeegyo bilaash ah, U tag shaqaalaha wixii kaalmo ah.	Soomaali
Spanish	Ofrecemos asistencia lingüística, así como también ayuda y servicios auxiliares adecuados, de forma gratuita. Consulte al personal para obtener ayuda.	español
Tagalog	Naghahatid kami ng tulong sa wika at ng naaangkop na mga kasamang tulong at serbisyo nang libre. Makipag-ugnayan sa mga kawani para sa tulong.	Tagalog
Tongan	'Oku mau fakahoko 'a e tokoni 'i he leá mo vahevahe 'o 'ikai ha totongi 'a e ngaahi naunau mo e sēvesi tokoni ki ha faingata 'a 'ia fakaefetu'utaki. Sio ki ha taha ngāue ke tokoni atu.	faka-Tonga
Vietnamese	Chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ cùng với các dịch vụ và trợ giúp bổ sung phù hợp miễn phí. Vui lòng đến gặp nhân viên để được hỗ trợ.	tiếng Việt



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