Montrose Memorial Hospital Financial Assistance Application

Montrose Memorial Hospital is proud to provide quality and affordable healthcare to our community. Our financial counselors are always here to assist those in need of financial assistance. To assist in this process, we will require this application along with supporting documentation outlined on page 4. If you feel that you need to offer additional information relating to this application, space has been provided on page 5. It is important that this application be filled out completely and returned with the required documents to Montrose Memorial Hospital via mail or in person at the below address. If this is not completed prior to service, the form must be completed and returned within 14 days of service. If for any reason the information above or within this application cannot be obtained, please call a financial counselor at 1-970-252-2687. Hour of operation are Monday - Thursday from 7:30 AM until 5:00 PM or Friday's from 7:30 AM until 12:00 PM and they are always available to help.

Please mail this completed, signed form, or bring in the form completed, or we can help you complete it at:

Montrose Memorial Hospital – Floor 1

800 S. 3rd Street

Montrose, CO 81401

If you do plan to bring the form in, we highly recommend that you call 1-970-252-2687 and make an appointment so that we can provide you with the best customer service possible and limit any waiting time.

Health Care Financial Assistance Application

General Information

Patient Name_____ Account # _____

Social Security Number _____ Date of Birth _____

Address _____

City _____ State_____ Zip_____ County _____

Home Phone # _____ Cell Phone # _____ Work Phone #_____

Email _____

☐ Single ☐ Married/Significant Other ☐ Divorced/Separated ☐ Widow/Widower

Responsible Party Name _____ Relationship _____

Social Security Number _____ Date of Birth _____

Address _____

Home Phone # _____ Cell Phone # _____ Work Phone # _____

Spouse's Name_____

Social Security Number_____ Date of Birth _____

Address _____

Home Phone # _____ Cell Phone # _____ Work Phone #_____

Name(s) and age(s) of dependents living with you for whom you are responsible. Please include DOB:

_____ _____

_____ _____

_____ _____

INCOME

Prior year's **AGI** (Adjusted Gross Income) reported to the IRS (found on Form 1040) _____
If you did not file a tax return, please explain _____
_____

Current Employer _____

Address _____

Phone Number_____ Occupation _____

Length of Employment _____years _____months Full Time / Part Time _____
Number of hours scheduled to work each week _____

If unemployed, date of unemployment: _____ Are you receiving unemployment Yes / No _____
If *YES* – Beginning date_____ Amount receiving weekly_____

Spouse / Significant Other's Current Employer _____
Address _____

Phone Number _____ Occupation _____

Length of Employment _____years _____months Full Time / Part Time _____
Number of hours scheduled to work each week _____

If unemployed, date of unemployment: _____ Are you receiving unemployment Yes / No _____
If *YES* – Beginning date_____ Amount receiving weekly _____

Income on a Monthly Basis	**Yours**	**Spouse**	**Assets**	**Value/Balance**
Gross Pay			Current Home	
Alimony/ Child Support			Other Property (land, investment, rental, etc.)	
Social Security			Vehicle(s)	
Unemployment / Work Comp			Investments - Stocks, Bonds, Mutual Funds, 401k, IRA, Annuities	
Retirement / Pension			Savings Account I.	
Interest / Rental			Savings Account 2.	
Public Assistance			Checking Account	
Other			Other	
Monthly Total			Other	

(Office use only) Annual Total_____

EXPENSES

Name of Mortgage Holder or Landlord_____

Address_____

_____

	Monthly Payment	Outstanding Balance	Current Yes / No
Mortgage / Rent			
Home Owner's /Renter's Insurance			
HOA			
Telephone - home			
Cell Phone			
Electricity			
Gas			
Water			
Cable / Satellite / Dish			
Auto Loan			
Auto Loan			
Auto Insurance			
Transportation - Gas			
Life Insurance			
Health Insurance			
Medical Bills			
Prescriptions			
Food			
Child Care			
School Expenses / Loans			
Alimony / Child Support			
Credit Card Bills			
Internet			
Other			
Other			
Monthly Total			

(Office use only) Annual Total_____

OTHER

Do you receive food stamps? ☐Yes ☐No

Do you have medical benefits? ☐Yes ☐No

If no, have you applied for Medicaid? _____ Date Applied_____

If benefits were denied, what reason was given? _____

_____

Date Medicaid was denied _____

REQUIRED DOCUMENTS:

- **Completed, signed and dated application**
- **Copy of your last 3 months of pay stubs for you, spouse and/or significant other**
- **3 months bank statements (includes personal/savings/business accounts, displaying account owner's name and account number**
- **Copy of award letter(s) – Unemployment, Social Security, etc. displaying monthly benefit**
- **Child Support / Court Ordered Maintenance**
- **Copy of prior year's tax returns (all pages) must be submitted with this application. Cannot accept W2 forms.**
- **If unemployed and / or living with friend or family, page three (3) "Expenses" must be filled out**

If unemployed and living with family or friend

Page three (3) of the financial application must be completed showing what the monthly mortgage/rent, electric/gas and cable statements reflect. (Please do not provide receipts)

If Applicant of Spouse is self-employed:

Must provide copy of the business ledger for the last three (3) months

Non-US Residency

Provide a copy of your photo ID. Passport, Visa, etc.

Your signature is required to complete this application

My signature attests that the information provided on this form is accurate and true to the best of my knowledge. I understand that Montrose Memorial Hospital requires verification of income before any determination is made. I also understand that my credit may be accessed, at no expense to me, to verify the information above.

Signature_____ Date _____

Please use space below if needed:

_____
_____
_____
_____
_____
_____
_____
_____

Office Use Only:

Family Size_____ Income_____ Yearly Expenses_____ Poverty Level_____

Out Pt. Responsibility_____ In Pt. Responsibility _____ Clinic Responsibility_____Level:_____

Special Notes: _____

_____

_____

Financial Coordinator Name: _____ Approved Denied

Decision Date _____