

**Financial Assistance**

**Garfield Memorial Hospital**

**Return Information to:**

**MAIL:** Financial Assistance

PO Box 27327

Salt Lake City, Utah 84127

**FAX:** 385-831-2890

**EMAIL:** [financial.assistance@r1rcm.com](mailto:financial.assistance@r1rcm.com)

*If you need help to complete this form, please ask to speak with our Financial Assistance Department at 866-415-6556. Please check our website for additional information including Frequently Asked Questions, Plain Language Summary, and our Financial Assistance Policy. Patients may also apply online at* [*www.intermountainhealthcare.org/assistance.*](http://www.intermountainhealthcare.org/assistance)

## 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 in order to be processed.* *Financial assistance will not be awarded to those who do not complete the application process; including the requirement for hospital patients to apply for programs for which they may qualify (e.g., Medicaid).*

## Please submit the following documentation:

1. **Copies of your current federal tax return with all schedules, including W-2s.**
2. **Household income verification noted below.**

**Patient Name Account Number Birth Date**

Responsible

Party Name

Social Security

Number (optional)

Birth

Date

Relationship to Patient Home Phone Cell Phone Address City State Zip\_

Employer Name Work Phone

How long have you lived at this address? Years Months

# Please list addresses for the last 12 months:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Address** | **City** | **State** | **Zip** | **From (Month/Year)** | **To (Month/Year)** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

Spouse

Name

Spouse Social

Security Number(optional)

Spouse

Birth Date

Spouse Spouse Spouse

Home Phone Cell Phone Employer Name

# Additional Household Members

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Name** | **Birth Date** | **Relationship** |  | **Name** | **Birth Date** | **Relationship** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

**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) | | $ | $ |  Provide paycheck stubs for the last two pay periods or 3 months bank statements |
| Self-Employment Income (Gross) | | $ | $ |  Provide 3 months bank statements |
| Pension, Retirement, Social Security Income | | $ | $ |  Provide your Pension/Retirement statement, and/or Social Security award letter |
| Unemployment, Disability Income, etc.  Check if Disabled/unemployed longer than 6 months | | $ | $ |  Provide unemployment, disability award letter, or 3 months bank statements |
| Child Support, Alimony | | $ | $ |  Provide a copy of your divorce decree, legal separation notice, or custody agreement if you would like this information considered |
| Other *(Please list source*): |  | $ | $ |  Provide 3 months bank statements with an explanation of your income source(s) |
|  |

***Please turn to the back of this form to complete the application. ***

Fin Info 50146

Please itemize your outstanding medical expenses if you would like this information considered and, if known, indicate the amount still owed after the insurance company pays. Attach a separate sheet if necessary.

|  |  |  |
| --- | --- | --- |
| **Account #** | **Name of Provider (Hospital/Physician/Pharmacy)** | **Balance Due** |
|  |  | $ |
|  |  | $ |
|  |  | $ |
|  |  | $ |
|  |  | $ |

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

Does your employer or spouse’s employer offer group health insurance?  Yes  No If yes, list insurance company:

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

Were you denied for Medicaid? Attach copy of Medicaid denial (optional).  Yes  No Have you applied for state assistance programs (CHIP, PCN, Crime Victims, etc.)?  Yes  No

Do you have family or church assistance?  Yes  No If Yes, please provide details below

# Please explain any situation we should be informed of in order to understand your inability to pay the medical balance. 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. I authorize any required verification, including a credit bureau report. I understand that if this information is determined to be false or deceptive, I will be liable for payment of charges for all services rendered. I understand that this request for financial assistance may not pertain to other health care providers.***

# Responsible Party Signature Date

## Checklist of all required information to complete application process:

 Front and back of form filled out completely with signature and date.

 Copies of your current federal tax return with all schedules including W-2's

 Household income verification

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