

Financial Assistance Application

Return Information to:

Financial Assistance MAIL: PO Box 27327

Salt Lake City, Utah 84127

FΔX· 385-831-2890

EMAIL: 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 A sked Questions, Plain Language Summary, and our Financial Assistance Policy. Patients may also apply online at 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 the patient to apply for programs for which they may qualify (i.e. Medicaid).

Please submit the following documentation:

- 1. Copies of your current federal tax return with all schedules, including W-2s

atient Name		Account Nur	Account Number		Birth Date		
Responsible Party Name		Social Securit			Birth Date		
Relationship to Patient		Home P	Home Phone		Cell Phone		
Address		City_			State	_Zip	
Employer Name	ress?`	YearsMonths s:		Work	(Phone		
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 Nam <u>e</u>			
Additional Household Membe	rs						
Name Birth Date		Relationship	Relationship		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. Responsible **Spouse** Type of Income Verification Required **Type Party Amount Amount** ☐ Provide paycheck stubs for the last two pay periods or \$ Employment Income (Gross) \$ 3 months bank statements ☐ Provide 3 months bank statements \$ \$ Self-Employment Income (Gross) ☐ Provide your Pension/Retirement statement, and/or Pension, Retirement, Social Security Income \$ \$ Social Security award letter ☐ Provide unemployment, disability award letter, or 3 \$ \$ Unemployment, Disability Income, etc. months bank statements Check if Disabled/unemployed longer than 6 months ☐ Provide a copy of your divorce decree, legal \$ \$ Child Support, Alimony separation notice, or custody agreement if you would like this information considered ☐ Provide 3 months bank statements with an explanation Other (Please list source): \$ \$ of your income source(s)

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". ☐ Yes ☐ No If yes, list insurance company: _ Does your employer or spouse's employer offer group health insurance? Do you have other types of insurance such as Allstate, AFLAC, etc.? ☐ Yes ☐ No If yes, list insurance company: ___ Do you have a Health Savings / Flex Spending Account? ☐ Yes ☐ No If yes, list balance amount: \$__ Does your employer reimburse you for any deductible or healthcare costs? ☐ Yes ☐ No Were you denied for Medicaid? Please attach a copy of the Medicaid denial.

Yes
No you applied for state assistance programs (CHIP, PCN, Crime Victims, etc.)? ☐ Yes ☐ No eligible for COBRA through a previous employer? ☐ 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