Dear Patient,

The Mission of Intermountain Health is to be a model health system by providing extraordinary care and superior service at an affordable cost.

Please submit your **completed application along with required documents by:**

Mailing address: 500 Eldorado Blvd, Ste. 4300. Broomfield, CO. 80021.
Fax number: 303-272-0931.
Email: Peaks_Financialassistanceapps@imail.org

REQUIRED DOCUMENTS:

- **Financial assistance application- completed, signed, and dated**

- **Income verification for you, your spouse, or significant other. Acceptable verification(s):**
  - **Copy of your most recent or last pay stub *OR***
  - **Letter(s) from employer stating gross earnings for the last or current month**
  - **Copy of award letter(s) – Unemployment, Social security, pension payments, payments from retirement accounts, etc. displaying monthly income**
  - **Tips, bonuses, and commissions**

- **Self Employed Patients-**
  - **Business financial records, profit and loss statements or ledgers (for previous or current month) business bank accounts showing deposits and withdrawals, invoices, and receipts, etc*. Please reach out via email, if you would like a profit and loss template.***

To avoid delays in the application processing, please review your application to ensure it is completed, signed and dated. Include income verification for the last or current month, and dates of birth for all family members who reside in the home.

Thank you,
Financial Assistance Team

PATIENT INFORMATION **Are you a Colorado Resident? Yes____ No____ Experiencing Homelessness? Yes____ No____**		
Last Name First M.I.	Social Security Number	DOB
Street Apt # City State Zip Code	Email Address	Account Number
Home Phone	Cell Phone	
Preferred Method of Contact Email Phone Mail MyChart Portal	Family Size	
Monthly Gross Income	Pay frequency (please indicate) Weekly Bi-Weekly Twice a month Monthly	
SPOUSE / (PARENT INFORMATION IF MINOR)	Relationship to Patient	
Last Name First M.I.	Social Security Number - -	DOB
Home Phone	Cell Phone	
Monthly Gross Income	Pay frequency (please indicate) Weekly Bi-Weekly Twice a month Monthly	
Dependent	Relationship to Patient	DOB
Last Name First M.I.	Social Security Number - -	Home Phone
Dependent	Relationship to Patient	DOB
Last Name First M.I.	Social Security Number - -	Home Phone
Dependent	Relationship to Patient	DOB
Last Name First M.I.	Social Security Number - -	Home Phone

Please add additional dependents on separate form.

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)? Yes___ No___

Do you or any of the members in your household receive public benefits? (ie Food Stamps, WIC or Free or Reduced Lunches Yes ___ No ___

My signature attests that the information I have provided on this form is accurate and true to the best of my knowledge. I understand that Intermountain Health requires verification of income before any determination is made.

Applicant Signature:____ Date:____________________