Intermountain Healthcare

Financial Assistance Application

Return Information to:
MAIL: Financial Assistance
PO Box 27327
Salt Lake City, Utah 84127
FAX: 801-442-0007
EMAIL: financial.assistance@imail.org

If you need help to complete this form please ask to speak with our Financial Assistance Department at 1-800-442-1128. 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. Intermountain Healthcare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-866-415-6556（TTY: 1-888-735-5906)

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**
2. **Household income verification noted below**

Patient Name **Account Number** **Birth Date**

Responsible Party Name_____ Social Security Number_____ 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_____ Spouse Birth Date_____

Spouse Home Phone _____ Spouse Cell Phone_____ Spouse 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
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.

Assets

Type	Financial Institution(s)	Total Balance Amount (Approximate as accurately as possible)
Cash		$
Savings Account(s)		$
Checking Account(s)		$
Stocks or Bonds		$
For Medicare Patients Only (as required by Medicare):		
401(k)		$
IRA		$

Please itemize your outstanding medical expenses 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:_____
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
Have you applied for state assistance programs (CHIP, PCN, Crime Victims, etc.)? ❑ Yes ❑ No
Are you 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