

Financial Assistance Application

Return Information to:

MAIL: Financial Assistance

PO Box 27327

Salt Lake City, Utah 84127

FAX: 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 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 Nu	Account Number		Birth Date		
Responsible Party Name		Social Securi			Birth Date		
Relationship to Patient					Cell Phone		
Address_				StateZip			
Employer Name			Work Phone				
How long have you lived atthis a Please list addresses for th	ddress? e last 12 month	YearsMonths					
Address		City	State	Zip	From (Month/Year)	To (Month/Year)	
Spouse Name			Spouse Social Security Number			Spouse Birth Date	
ouse Spouse			Spouse				
Additional Household Mem	bers						
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. 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)



	ays. Attach a separate sheet if necessary.	(Pharman)
Account #	Name of Provider (Hospital/Physician	n/Pharmacy) Balance Due
		\$
		\$
		\$
		\$
		Φ
pes your employer or sp e any of your medical bi e you enrolled in a medi pes your employer reimb ere you denied for Medi	ouse's employer offer group health insurance? ills due to an auto or work-related accident? ical Healthshare plan? ourse you for any deductible or healthcare costs? caid? Attach copy of Medicaid denial if applicable. e assistance programs (CHIP, PCN, Crime Victims, etc.	her funding also. Please check "Yes" or "No". Yes No If yes, list insurance company: Yes No If yes, list insurance company: Yes No If yes, please provide explanation of share (E Yes No Yes, please provide details below
ease explain any sit	uation we should be informed of in order to	o understand your inability to pay the medical balanc
	arate sheet if more space is needed. Additi	
ureau report. I unders r all services rendere	tand that if this information is determined to b	l authorize any required verification, including a credit re false or deceptive, I will be liable for payment of charge ressistance may not pertain to other health care providers Date
	Checklist of all required information of form filled out completely with signature and date urrent federal tax return with all schedules including ne verification	

Please itemize your outstanding medical expenses if you would like this information considered and, if known, indicate the amount still owed after