Intermountain Healthcare

Mail to:

Fax to:

Financial Assistance Application

If you need help to complete this form please ask to speak with our Financial Assistance Department at 1-800-442-1128.

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. Patients may not receive financial assistance if they do not complete the application process.

Please submit the following documentation:

1. **Copies of your current federal tax return with all schedules, including W-2s**
2. **Household income verification (paycheck stubs) for the last two pay periods**

Patients may not receive financial assistance if they potentially could have qualified for programs, such as Medicaid, but choose not to apply.

Patient Name _____ **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 Work Phone _____

Spouse Employer Name _____

Additional Household Members

Name	Birth Date	Relationship

Name	Birth Date	Relationship

Household Monthly Income

Type	Amount
Employment Income (Gross)	$
Employment Income for Spouse (Gross)	$
Pension / Retirement, Unemployment, Disability Income, etc.	$
Child Support	$
Grants/Scholarships	$
Alimony	$
Other *(Please list source):* _____	$

Fin App 50146

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 Savings Account? ❑ Yes ❑ No If yes, list balance amount: $ _____
Does your employer reimburse you for any deductible? ❑ 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

Other situations 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 documentation may be required.

I hereby state that the information given herein is true and correct. I authorize any 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 also understand that if my financial circumstances change within 3 year(s), so that funds become available, I will notify Intermountain and it will determine if some or all of the charges need to be paid. This request for financial assistance does 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
❑ Signed and dated
❑ Copies of your current federal tax return with all schedules, including W-2s
❑ Household income verification (paycheck stubs) for the last two pay periods