Financial Assistance Application

Prior to filling out our FA application please visit https://www.healthfirstcolorado.com/ or call 1-800-250-7741 Monday-Friday, 7:30 a.m. to 5:15 p.m. Medicaid denial is required for our FA application.
Upon approval, discounts will be applied to the applicable services rendered at Memorial Regional Health.

Name: __________________________________ SS#_____________________________

Address:_________________________________ Telephone#______________________

____ DOB: ___________________________

☐ Please check here if you have recently experienced a job loss or significant life event

Please explain: ____

Total number living in the home_____ * **ALL** people living in the home must be listed **(EVEN IF NOT RELATED)**

List **ALL** household income and attach verification for **EVERY** person in the household

Name (First and Last)	Relationship	DOB	SSN	Gross Monthly income	Health Insurance
___________________	____________	_________	______________	___________	**Y / N**
___________________	____________	_________	______________	___________	**Y / N**
___________________	____________	_________	______________	___________	**Y / N**
___________________	____________	_________	______________	___________	**Y / N**

If you answered "Yes" to Health Insurance, please fill out this section

If you answered "No," continue to the next section.

Insured's Name ________________________ Insurance Company Name _________________________

Insured's Name ________________________ Insurance Company Name _________________________

Insured's Name ________________________ Insurance Company Name _________________________

Insured's Name ________________________ Insurance Company Name _________________________

Members listed will be cross-checked with our records. Applications with discrepancies will be returned for additional information

Please attach copies of the following documents:

1. Most recent year's tax return showing your annual income

2. Three most recent pay stubs
3. Any additional income that may apply
4. Social Security / Pension Benefits or Award Letter
5. Three most recent bank statements showing direct deposits for all accounts including savings and money market accounts
6. Interest statements
7. Divorce / Custody decrees stating payments to be made
8. Foster Care / Adoption Subsidy agreements
9. Retirement / IRA Balances showing withdrawals
10. All liquid assets

Continued on next page

**** Applications for discounted services will be returned if all required documents are not attached****
**** MRH Business Office will review your application and notify you within 2 weeks.****
**** Must re-apply for each Medical Situation****

I authorize Memorial Regional Health to submit this Financial Assistance Application to make a determination of my eligibility for Medicaid, CICP, and / or Sliding Scale Fee for services rendered by the hospital. I understand the information I have submitted is subject to verification by MRH. I also understand that if the information which I submit is determined to be false, such a determination will result in a denial for Financial Assistance and I will be liable for payment in full.

I affirm that the above and attached information is true and accurate to the best of my knowledge. If I become eligible for Financial Assistance and do not make the required payments, I am aware that the account(s) for the household members listed above be sent to a collection agency.

APPLICANT SIGNATURE: ____ DATE: ___________

MRH Representative Signature___________________________________ DATE: ____________

750 Hospital Loop Craig, Co 81625 Phone# 970-826-3125 Fax: 970-826-3116

Do Not Write Below This Line

For Staff Purpose Only

_________________ Date application received

_________________ Date additional documents received

_________________ Date of approval / denial

_________________ CICP approval rate

_________________ Adjustment requested on sliding scale

Financial Counselor Signature: ________________________________ Date: ____________

Supervisor Signature: _______________________________________ Date: ____________