	<u> X </u> MRH    ___ CC <u> X </u> RHC		1 of 3
	<b>DOCUMENT TITLE</b> <b>Financial Assistance Application</b>		
<b>Document Type</b>	<u> X </u> Policy <u> X </u> Procedure    ___ Protocol    ___ Guideline		
<b>Department</b>	Revenue Cycle	<b>Effective</b>	06/30/2025

## 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


<u>Name (First and Last)</u>	<u>Relationship</u>	<u>DOB</u>	<u>SSN</u>	<u>Gross Monthly income</u>	<u>Health Insurance</u>
_____	_____	_____	_____	_____	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 \_\_\_\_\_

	<input checked="" type="checkbox"/> MRH <input type="checkbox"/> CC <input checked="" type="checkbox"/> RHC	2 of 3
<b>DOCUMENT TITLE</b>	<b>Financial Assistance Application</b>	
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<b>Department</b>	Revenue Cycle	<b>Effective</b> 06/30/2025

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

\*\*\*\* Applications for discounted services will be returned if all required documents are not attached\*\*\*\*


\*\*\*\* MRH Revenue Cycle Department will review your application and notify you within 2 weeks.\*\*\*\*

I authorize Memorial Regional Health to submit this Financial Assistance Application to make a determination of my eligibility for Medicaid, HDC, 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: \_\_\_\_\_

 memorial regional health	<input checked="" type="checkbox"/> MRH <input type="checkbox"/> CC <input checked="" type="checkbox"/> RHC	_____ 3 of 3
<b>DOCUMENT TITLE</b>	<b>Financial Assistance Application</b>	
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		06/30/2025

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

Do Not Write Below This Line

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For Staff Purpose Only

\_\_\_\_\_ Date application received

\_\_\_\_\_ Date additional documents received

\_\_\_\_\_ Approval SFS percentage

\_\_\_\_\_ Denied

Financial Counselor Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Supervisor Signature: \_\_\_\_\_

Date: \_\_\_\_\_

# Document Information

## Document Title

Application for Sliding fee

## Document Description

N/A

## Approval Information

**Note:**