Intermountain Health

Return Information to:
MAIL: 500 El Dorado Blvd Ste 4300
Broomfield, Co 80021
FAX: 303-272-0931
EMAIL: Peaks_financialassistanceapps@imail.org

Financial Assistance Application for Colorado and Montana Facilities

Instructions for completing this form:
Please fill this form out completely and return all required documentation to the Intermountain facility where you had care or to one of the contact methods listed above for your application to be processed. Financial assistance will not be awarded to those who do not complete the application process.

Please submit the following documentation:

1. **Financial Assistance application: completely filled out, signed, and dated.**
2. **Current Household income verification noted below.**

Are you a Colorado Resident? **Yes_____ No _____**

Current Household size _____

Experiencing Homelessness? **Yes_____ No _____**

First and Last Name_____ **Social Security Number**_____ **Birth Date**_____

Marital Status:_____Home Phone_____Cell Phone _____

Address_____City_____State_____Zip_____

Employer Name_____ Work Phone _____

How long have you been employed by this employer? _____Years_____Months

Pay Frequency (please indicate) Weekly_____ Bi-weekly_____Twice a month_____ Monthly_____

Spouse Name _____ **Spouse Social Security Number**_____ **Spouse Birth Date**_____

Spouse Home Phone_____Spouse Cell Phone_____

Spouse Employer Name_____Work Phone_____

How long have you been employed by this employer?_____Years_____Months

Pay Frequency (please indicate) Weekly_____ Bi-weekly_____Twice a month_____ Monthly_____

Additional Household Members/Dependents. Please add any additional dependents on a separate form.

First and Last Name	Birth Date	Social Security Number	Relationship

Current Household Monthly Income

Type	Patient Amount	Spouse Amount	Other Adult Household member/s	Type of Income Verification Required
Employment Income (Gross)	$	$	$	*Copy of the most recent or last paystub or a letter(s) from your employer(s) stating gross earnings for the last or current month*
Self-Employment Income (Gross)	$	$	$	*Profit and loss statement or ledgers for previous or current month. Current tax return if applicable.*
Pension, Retirement, Social Security Income	$	$	$	*Copy of current award letter(s), pension payments, payments from retirement accounts etc. Displaying monthly income.*
Unemployment, Disability Income, etc.	$	$	$	*Copy of current award letter(s)*
Other *(Please list source/s)*:_____ _____	$	$	$	*Ex: Tips, bonuses, and commissions*

Additional Questions: Answering these questions ensures your application processing isn't delayed for further information.	**Yes**	**No**
Is anyone in your home currently pregnant?	☐ Who in the household is pregnant? _____ Due date? _____	☐
Do you provide 50% or more financial support to someone living outside your home that would like included in your household size calculation (individual may live out of state/country)?	☐	☐
Do you or any members in your household receive public benefits? (i.e. Food Stamps, WIC or Free or Reduced Lunches)	☐	☐
Do you or any members in your household currently have health insurance?	☐ If yes, please list the name of your insurance carrier_____ _____	☐
Have you or any of your current household members applied for Medicaid, Medicare, or CHP+?	☐ If yes, please list the date you applied_____ _____	☐
Are any of your medical bills with our facilities related to an auto or work-related accident?	☐ If yes, please list the insurance company_____ _____	☐
Are you enrolled in a Medical Healthshare or cost share plan?	☐ If yes, please provide an explanation of share (EOS)_____	☐

I hereby state that the information given herein is true and correct to the best of my knowledge. I understand that Intermountain Health requires verification of income before any determination is made.

Applicant Signature_____ **Date**_____

Checklist of all required information to complete application process:

❑ Financial assistance application completely filled out, signed, and dated.
❑ Household income verification.