VAIL HEALTH

FINANCIAL ASSISTANCE APPLICATION

Thank you for choosing Vail Health for your health care needs. We are committed to improving the health and well-being of everyone in our community. To that end, we are pleased to offer our financial assistance to help individuals and families in need.

HOW TO COMPLETE THIS APPLICATION:

1. Fill out all requested information in the application on the following pages.
2. Gather all requested documentation listed in the box below.
3. Submit completed application by mail or in person as soon as possible after date of service.

EMAIL: FinancialAssistance@VailHealth.org

MAIL: PO Box 40,000, Vail, CO 81658 | Attn: Financial Assistance Department

IN PERSON: Vail Health Hospital - Admissions Department: 180 South Frontage Road West, Vail, CO 81657

WHAT'S NEXT?

You will receive an eligibility letter from the Vail Health Financial Assistance department within sixty days after submitting a completed application with appropriate supporting documents.

If you have questions about this application or the requested documents, please contact a financial counselor at (970) 477-3116.

REQUIRED DOCUMENTATION Please provide documents from each category below, as applicable.

PHOTO ID/PROOF OF IDENTIFICATION

- Current driver license or state identification
- Current passport

PROOF OF INCOME (for each household member, provide all documents that exist and/or apply)

- Copy of the most recent filed income tax return, if not filed copy of the most recent W-2's.
- Copy of the two most recent paystubs for all jobs held throughout the year. If paid in cash, a Notarized Letter from each employer indicating terms of employment, including wages, salary, dates of employment, current employment status, the availability of any health care benefits, etc.
- If self-employed, year to date business records including income, expense, liabilities, and assets.
- Need copy of year-to-date payment summary for Unemployment and/or most recent award letter for SSI/SSDI
- Copies of checks for child or spousal support.
- Proof of other income (for example, interest income, pension, rental income).

PROOF OF RESIDENCY

- Copy of rent lease or a most recent mortgage statement. If no lease is in place, please provide a Notarized Letter from your landlord to include name of tenant(s), dates of residency, physical address, and rental cost/arrangements.

Completion of this form is not a guarantee of eligibility for financial assistance or any other program. Financial assistance is considered after all possible sources of potential payment have been exhausted (for example, health insurance, Medicare, Medicaid, liability insurance). Failure to provide requested documents may result in non-approval.

If you have any questions, please contact a financial counselor at (970) 477-3116

GENERAL INFORMATION

Patient Name:		Date of Birth:
Mailing Address:		
City:	State:	Zip Code:
Phone Number:		

Guarantor Name (if different than patient):		
Relationship:		Date of Birth:
Guarantor Mailing Address:		
City:	State:	Zip Code:
Phone Number:		

Check one: ☐ Single ☐ Married/Significant Other ☐ Divorced/Separated ☐ Widow/Widower

Spouse's Name:		Date of Birth:
Address:		
City:	State:	Zip Code:
Phone Number:		

Name(s) and age(s) of dependents living with you for whom you are responsible:

List any other additional household members:

INCOME

PROOF OF INCOME: Such as two most recent pay stubs, most recently filed tax return, if not filed – current year's W-2's, unemployment statements, Social Security or retirement statements.

If you did not file taxes, please explain:

Current employer (last date of employment if unemployed):

Employer address:

Occupation:	Employer phone:
Length of employment:	Hours worked per month:

Are you collecting unemployment?

Do you have more than one job?

If yes, please provide details:

Spouse's current employer (last date of employment if unemployed):

Employer address:

Occupation:	Employer phone:
Length of employment:	Hours worked per month:

Is your spouse collecting unemployment?

Does your spouse have more than one job?

If yes, please provide details:

Please list any additional employment information:

STATE ASSISTANCE

Do you have medical benefits?

If no, have you applied for Medicaid?	Date Applied:
Have you applied for Social Security Disability?	Date Applied:

If benefits were denied, what reason was given?

TOTAL HOUSEHOLD INCOME	Monthly Income	YTD Income	Other
Gross Pay (before taxes)			
Alimony/Child Support			
Social Security			
Unemployment/Work Comp			
Interest/Rental			
If Self Employed: Gross and net pay income			
Other			
TOTAL		**TOTAL**	

YOUR SIGNATURE IS REQUIRED TO COMPLETE THIS APPLICATION.

My signature attests that the information I have provided on this form is accurate and true to the best of my knowledge.

Signature Date

We are here for you. *Vail Health complies with applicable Federal Civil Rights Laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.*