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 who need assistance.

Attached is our Financial Assistance Application. Please fill out the application and submit with the required documentation as soon as possible after the date of service. If you have questions about the documents, please contact a financial counselor at the number below and he/she will assist you. Thank you for your cooperation.

DOCUMENTS REQUESTED FOR DETERMINATION OF ELIGIBILITY FOR FINANCIAL ASSISTANCE

Please provide documents from each category as applicable

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

- Copy of the two most recent paystubs. 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, business records including income, expense, liabilities, and assets for the past two months.
- Copies of checks or award letters from unemployment, Social Security.
- Copies of checks for child or spousal support.
- Proof of other income (for example, interest income, pension, rental income).
- Copy of the most recent filed income tax return.

PHOTO ID/PROOF OF IDENTIFICATION

- Current Drivers License or State ID
- Current Passport

DISCLOSURE OF ASSETS (for each household member, provide all documents that apply)

- Past two months of detailed statements from Checking and Savings accounts, Certificates of Deposit, Money Market Fund, Trust Fund, or Brokerage Statement, Retirement Plan, and/or Title of Vehicle(s) owned.

EXPENSES

- Copy of rent lease (for the last 6 months) / mortgage statement, most recent statements for all monthly expenses such as utility bills, credit card statements, car payments and/or any other that may apply.

Please submit the requested documents to the hospital's financial counselor in person or by mail at PO Box 40,000 Vail, CO 81657, Attention: Financial Assistance Department. You will receive a determination of Eligibility for Financial Assistance letter within thirty days after receiving a completed application with appropriate supporting documents.

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 (for example, health insurance, Medicare, Medicaid, liability insurance) have been exhausted. Failure to provide requested documents may result in non-approval.

If you have any questions, please contact us at:
(970) 477-3116 *Direct* | (970) 470-6638 *Vail Fax* | (970) 470-6415 *Edwards Fax*

Thank you, Financial Counselor

GENERAL INFORMATION

Patient Name:

Account Number/s: Date of Birth:

Address:

City: State: Zip Code:

Phone Number:

Guarantor Name (if different than patient):

Relationship: Date of Birth:

Guarantor Address:

City: State: Zip Code:

Phone Number:

Circle 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 most current year's W-2, two most recent pay stubs, most recently filed tax return, 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 a 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 a 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 receive food stamps?

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?

MONTHLY INCOME	Total Household Income	Assets	Value
Gross Pay (before taxes)		Current Home	
Alimony/Child Support		Other Property	
Social Security		Vehicle(s)	
Unemployment/Work Comp		Stock, Bonds, Mutual Funds, 401K and Annuities	
Interest/Rental		Savings Account 1	
Other		Savings Account 2	
Other		Checking Account	
Other		Loan Documents	
TOTAL		**TOTAL**	

EXPENSES	Monthly Payment	Balance Remaining
Mortgage/Rent		
Home/Renter's Insurance		
Telephone		
Electricity		
Gas		
Water		
Cable		
Auto Loans		
Transportation		
Life Insurance		
Health Insurance		
Medical Bills		
Prescriptions		
Food		
Child Care		
School Expenses/Loans		
Alimony/Child Support		
Credit Card Bills		
Other		
Other		
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.*

Estamos aquí para tí. *Vail Health cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.*