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.

   MAIL: PO Box 40,000 Vail, CO 81657 | Attn: Financial Assistance Department

   IN PERSON: Vail Health Hospital - Admissions Dept: 181 W Meadow Dr. 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.

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 driver license or state identification
- 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 and/or retirement fund.

EXPENSES

- Copy of rent lease (for the last six months) or a mortgage agreement. 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:

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 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 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		Stocks, 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.*