



Financial Assistance Application for Utah, Idaho and Nevada Facilities

Return Information to:
MAIL: Financial Assistance
 PO Box 27327
 Salt Lake City, Utah 84127
FAX: 385-831-2890
EMAIL: financial.assistance@r1rcm.com

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. You can also apply online via MyChart. 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.

Account Number _____ **Current Household Size** _____ **Experiencing Homelessness?**
 Yes ___ No ___ **What state do you live in?** _____

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

Marital Status _____ **Email** _____ **Phone #** _____

Address _____ **City/County** _____ **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 _____

How long have you lived at this address? _____ Years _____ Months If **less than three months**, please list previous address:

Address	City	State	Zip	From (Month/Year)	To (Month/Year)

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. Include unborn child if applicable Please add any additional dependents on a separate form. (Household members must match the current household size question listed above)

First and Last Name	Birth Date	Social Security Number	Relationship

Current Household Monthly Gross Income

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

Additional Questions: Answering these questions ensures your application processing isn't delayed for further information.

	Yes	No
Do you or any members in your household receive public benefits? (i.e. Food Stamps, WIC or Free or Reduced Lunches)	<input type="checkbox"/>	<input type="checkbox"/>
Are you currently receiving or plan on receiving care at an Intermountain Health Cancer Center?	<input type="checkbox"/>	<input type="checkbox"/>
Do you or any members in your household currently have health insurance?	<input type="checkbox"/> If yes, please list the name of your insurance carrier _____ _____	<input type="checkbox"/>
Have you or any of your current household members applied for Medicaid, Medicare, CHIP or CHP+? <i>If yes and denied, please provide denial letter</i>	<input type="checkbox"/> If yes, please list the date you applied _____ _____	<input type="checkbox"/>
Are any of your medical bills with our facilities related to an auto or work-related accident?	<input type="checkbox"/> If yes, please list the insurance company _____	<input type="checkbox"/>
Are you enrolled in a Medical Health Share or Cost Share plan?	<input type="checkbox"/> If yes, please provide an explanation of share (EOS) _____ _____	<input type="checkbox"/>
Is anyone in your home currently pregnant?	<input type="checkbox"/> Who in the household is pregnant? _____ Due date? _____	<input type="checkbox"/>

We ask patients who apply for financial assistance to look for other funding also. Please check "Yes" or "No".

- Does your employer reimburse you for any deductible or healthcare costs? ___ Yes ___ No
- Have you applied for any state assistance programs such as Crime Victims? ___ Yes ___ No

If needed, use the space below for further explanation of the reason you are requesting financial assistance. You may attach a separate sheet if more space is needed. Additional verification may be required.

I hereby state that the information given herein is true and correct to the best of my knowledge. I understand if I mislead or provide false information to obtain financial assistance with Intermountain Health, the request will be denied and may impact future requests for assistance.

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.