Financial Assistance Application Summary

Must be filled out completely (Please Print)

Applicant Full Legal Name:		Birth Date:	Telephone Numbers Cell:
U.S. Citizen? Yes ( ) No ( )	Resident Alien? Yes ( ) No ( )	Health Insurance ? Yes ( ) No ( )	Home/Work:

Spouse Full Legal Name:		Birth Date:	Telephone Numbers Cell:
U.S. Citizen? Yes ( ) No ( )	Resident Alien? Yes ( ) No ( )	Health Insurance ? Yes ( ) No ( )	Home/Work:

Street Address:			Own_____ Rent____ Other____
City	State:	Zip:	How Long at this address?_____
			If Other, Explain:_____

Mailing address if different from street address

Mailing Address:		
City	State:	Zip:

If less than 2 years at present address, list prior address below

Street Address:			Own_____ Rent____ Other____
City	State:	Zip:	How Long at this address?_____

Valley View Hospital

(970) 384-6890

www.vvh.org

HOUSEHOLD INFORMATION / **INCOME INFORMATION**

Member Name	SS#	Date of Birth	Relationship	Source/Description	Frequency (week,month,etc)	Amount
			Applicant			$
						$
						$
						$
						$
						$

Monthly Health Insurance Premium: $	Medical Expenses incurred last 12 months: (Excluding Valley View Hospital) $

ASSETS		LIABILITIES	
Value of Primary Home	$	Primary Home Mortgage(s)	$
Value of all other Real Estate Owned	$	Other Real Estate Loans	$
Checking Account Balance(s)	$		$
Savings/Money Market/CD's/Stocks	$		$
Number of Automobiles,Boats,Motorcycles,ATV's owned		Loan balances on Vehicles	$
Value of all Vehicles listed above	$		$
Other:	$		$

VALLEY VIEW HOSPITAL
FINANCIAL ASSISTANCE DOCUMENT REQUEST

NOTICE: IF YOU HAVE CHILDREN YOU MUST APPLY FOR MEDICAID SIMULTANEOUSLY TO APPLYING FOR VVH FINANCIAL ASSISTANCE. PLEASE SPEAK TO ONE OF OUR FINANCIAL COUNSELORS WHEN YOU SUBMIT YOUR REQUEST.

- ☐ **1. Healthcare Financial Assistance Application**
  - ☐ Completed
  - ☐ Signed
- ☐ **2. Identification documents (for all family members)**
  - ☐ Driver's License or other Photo Identification
  - ☐ Social Security Card and/or proof of immigration status
  - ☐ Birth Certificates for all household minors
  - ☐ Health Insurance Cards
- ☐ **3. Income Verification**
  - ☐ Two consecutive most recent pay stubs
  - ☐ Award letter for Social Security, pension, unemployment, disability and other sources
  - ☐ If Self Employed or you receive Rent Income, year-to-date income & expense statement
- ☐ **4. Signed and notarized Letter of Financial Support if you are receiving free room and board or other financial support from family, friends or others.**
  - ☐ Use separate Letter of Financial Support Form for each source (Exhibit B)
- ☐ **5. Copies of two most recent consecutive bank account statements:**
  - ☐ Personal Checking
  - ☐ Savings /Certificates of Deposit
  - ☐ Business Checking
  - ☐ Brokerage/IRA/401k/Cash Value of Life Insurance/etc.
  - ☐ Liquid assets held in a trust
- ☐ **6. Verification of Assets:**
  - ☐ County Real Estate Assessments for all property owned
  - ☐ Registrations for all vehicles owned (autos, motorcycles, boats, RV's, etc)
- ☐ **7. Tax return information:**
  - ☐ Form W-2 for most recent year
  - ☐ Personal Tax Returns for most recent two years
  - ☐ Business Tax Returns for most recent two years (Year end business financial statements if taxes not yet filed)
- ☐ **8. Copies of receipts & medical bills paid in the 12 months prior to the application date.**
- ☐ **9. Other Documents as requested by Hospital Staff complete your application.**
  - ☐ _____

Please note:

1. ***Please provide legible copies of all documents***
2. ***Identification documents must be copied front and back***
3. ***Letter of Financial Support (Exhibit B) must be notarized.***

All of the applicable information must be returned within 15 days for your application for financial assistance to be considered.

I understand that all of the information on my application and supporting documentation must be true to the best of my knowledge or my application will be denied.

_____ _____

VVH Authorized Signature Date Signature of Applicant Date

Contact Customer Service at 970-384-6890 or 866-231-7678 toll free if you have any questions.

Valley View Hospital

Exhibit B

Letter of Financial Support

Patient Name _____

Account Number _____

This is to certify that I, _____, _____
Supporter Relationship

of Patient, _____, provide assistance for this

Patient and have done so for _____ weeks/months/years.

( ) I provide room and board to the above individual valued at $_____ per month

( ) I provide the above individual $_____ per week/month/year

( ) I provide other assistance as follows (include description and $$ value):

I acknowledge all of the information provided to be true. I understand that providing false information will result in denial of the application.

_____
Signature

State of Colorado
County of _____

The foregoing instrument was acknowledged before me this ___ day of _____, 20____

by _____

_____
(Notary's official signature)

_____
(Commission expiration date)