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:_____

Valley View Hospital

(970) 384-6890

www.vvh.org

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?_____

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:	$		$

I certify that the information provided above is an accurate and true representation of my financial information. I also certify there is no additional insurance coverage for this family other than what has been presented to Valley View Hospital (VVH).

Applicant Signature _____ Date _____ Spouse Signature _____ Date _____

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
  - ☐ Unemployment award letter
  - ☐ Award letter for Social Security, pension, 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:**
  - ☐ Personal Tax Returns for most recent two years (Form W-2 for most recent year if taxes not yet filed)
  - ☐ Business Tax Returns for most recent two years (Year end business financial statements if taxes not yet filed)
- ☐ **8. Copies of all medical bills incurred during the past year 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.

Exhibit B

Valley View Hospital

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)