Memorial Hospital of Carbon County

Financial Assistance Application

To Whom It May Concern,

I'm providing you with a Financial Assistance Application for Memorial Hospital of Carbon County. I will need this application completed in its entirety along with all of the additional requirements. Once completed, you can mail or drop it off as follows:

Mail:		**Drop Off:**
MHCC Business Office	OR	MHCC Business Office
P.O. Box 460		2221 W Elm Street
Rawlins, Wyoming 82301		Rawlins, Wyoming 82301

Once the application has been received, we will file it until all documentation has been obtained. If you would like to set up an appointment to discuss any issues or concerns regarding this application, please contact me at the number below. We have also attached a copy of our payment policy to the bank of this application, please remove it, and keep it for your records.

Sincerely,

Madison Acton
Business Office Supervisor
(307)-324-8293
macton@imhcc.com

Felicia Kimble
Director of Revenue Cycle
(307) 324-8300
fkimble@imhcc.com

Financial Assistance Program Application

Date: _____

Dear Patient,

The following forms will be used with your Financial Assistance Application for Memorial Hospital of Carbon County. This is a program that allows any uninsured, or underinsured qualifying low income patient to receive an adjustment off of their hospital bills from 25% up to 100%. (See patient payment policy and financial assistance policy for additional information.) Please return the completed forms and all applicable documentation within 30 days from receiving this application.

Verification of financial status and family size are required. See the attached detailed checklist of documents we require to be able to process your application for financial assistance. If something does not apply to you, please write "not applicable" or "N/A". Should you have any questions, please do not hesitate to contact the Financial Counselor. Your prompt response is greatly appreciated.

Please remember:

1. Fill out all of the forms completely, that are attached in this packet.
2. Gather all applicable documentation listed on the attached document. If you are self-employed, please provide Profit and Loss Statement for the last six months.
3. Return this information to the Admission window at the Hospital Patient Financial Services Office or mail to: P.O. Box 460, Rawlins, WY 82301 by _____.

Thank you for your interest in applying for Financial Assistance with Memorial Hospital of Carbon County. This application, if approved can cover emergent only emergency room visits, office visits with MHCC staff and any procedures deemed medically necessary by your primary care physician. Any service is subject to review for medical necessity by MHCC administration. You should receive a letter of approval or denial after all documentation is obtained and administration has reviewed your file. The approval/determination of this application will expire 6 months from the date application is completed. If approved for less than 100% charity/FPL you will be responsible for that remaining balance, and payment must be received within 90 days of date of service, all facility collection policies apply to any patient responsibility. Any services rendered after that date will require a re-evaluation of your financial situation and submitting another application or setting up a payment arrangement.

Thank You,

Madison Acton
Business Office Supervisor
(307) 324-8293
macton@imhcc.com

Felicia Kimble
Director of Revenue Cycle
(307) 324-8400
fkimble@imhcc.com

The following documentation is required when applying for the Financial Assistance Program

_____Most recent complete Federal Income Tax Return and W-2 withholding statement.

_____Three of most recent, consecutive paycheck stubs OR a statement from the employer to include employer name, address, phone number, tax ID number, hire date, rate of pay, and hours per week.

_____Most current Self Employed Gross Deposits for three consecutive months and most current full month Profit and Loss Statement.

_____3 months of bank statements, showing savings account balance if applicable.

_____Retirement/pension benefits stubs.

_____Social Security Income (yearly benefits statement).

_____Government assistance notices (including Department of Health & Human Services, Medicaid, Aid to the Needy and Disabled, TANF, LEAP, WIC, etc.). *Medicaid Denial letters are not accepted for NHSC

_____If no income, two letters written by friends/relatives including name, address and phone number stating the type of support being provided.

_____Driver's License or Photo Identification for each member of the household over the age of 18 applying for Financial Assistance.

_____Proof of Residency.

Confidential Financial Information: Memorial Hospital of Carbon County

Patient Name:
Hospital Number:
Clinic Number:

Responsible Party

First name	MI	Last	Marital Status (optional)	Social Security Number (optional)
Street Address, City, State, ZIP (Physical Address)			How long at this address	Home Phone
Employer's Name and Address (If Unemployed – How long)			Business Phone	
Position/Title			Length of current employment	

Spouse/Other

First name	MI	Last	Marital Status (optional)	Social Security Number(optional)
Street Address, City, State, ZIP (Physical Address)			How long at this address	Home Phone
Employer's Name and Address (If Unemployed – How long)			Business Phone	
Position/Title			Length of current employment	

Dependents/ANYONE WITHIN THE HOUSEHOLD UNDER 18 AND SHOWING ON YOUR W-2

Name & Year of Birth of all dependents in household First MI Last DOB	Total Number of Household Members:	Do Any Other Persons Contribute? If YES, Amount: Yes/No: Amount:
_____ _____ _____ _____	_____	Contribute to Expenses: Amount: $ _____

INCOME/LIABILITIES

	MONTHLY INCOME	
Gross Income (Salary and Wages)	**$**	
Spouse/Other Gross Income (Salary and Wages)	$	
Social Security	$	
Unemployment Compensation	$	
Worker's Compensation	$	
Child Support/Alimony	$	
Public Assistance/Food Stamps	$	

Grants	$	
Rental Income	$	
Dividends/Interest	$	
Office Use Only:		

Please explain any changes in family income that have occurred in the last 3 months:

_____

_____

_____

_____

_____

_____

_____

_____

Please explain in detail if any section of Income or Assets is left blank:

_____

_____

_____

_____

_____

_____

_____

_____

To my knowledge, the information provided within the application is true. I authorize a Credit Bureau Report to be secured by the Hospital or its agent to verify my financial standing.

_____ _____

Patient/Guarantor Signature **Date:**

Statement of No File for Federal Income Taxes

I, _____**(please print name)** hereby state that I have not filed federal income tax forms with the Internal Revenue Service of the USA in the past two years due to a low income status. I understand that my signing this form gives Memorial Hospital of Carbon County the right to verify this information, and deny me financial assistance if I am fraudulent.

_____ _____

Patient/Guarantor Signature: **Date:**