Memorial Hospital of Carbon County

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 to be completed in its entirety along with all of the additional requirements. Once completed, you can mail or drop it off as follows:

Mail: MHCC Business Office P.O. Box 460 Rawlins, Wyoming 82301	OR	Drop Off: MHCC Business Office 2221 W Elm Street 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 back of this application, please remove it, and keep it for your records.

Sincerely,

Felicia Kimble

Director of Revenue Cycle

(307) 324-8300

fkimble@imhcc.com

Memorial Hospital of Carbon County

Financial Assistance Program

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 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. 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.

Memorial Hospital of Carbon County

FINANCIAL ASSISTANCE PROGRAM

To ensure access to health care services provided by Memorial Hospital of Carbon County, a Financial Assistance Program is provided for eligible patients who are otherwise unable to pay for these services. If approved, Financial Assistance will cover accounts up to 240 days from discharge. Financial Assistance Program eligibility is based on Federal Poverty Income Guidelines, and financial ability to pay as determined through an application process. Elective procedures do not qualify for the Financial Assistance Program.

The following documents must be included with your completed application:

□ Documentation of income for 3 months - current pay stubs

□ Completed Financial Statement - attached

□ Tax Return - Including ALL pages and ALL Applicable W-2's

□ All documentation regarding unemployment and/or workers compensation, alimony, child support, WIC, Food stamps and/or other financial support.

□ Copy of the last 3 months bank statements.

□ Letter of Denial from Wyoming Public Assistance Program

CALL **1-855-294-2127** TO APPLY BY PHONE FOR WY MEDICAID Or login at http://www.wesystem.wyo.gov/AVANCE_ONLINE_APP

If you think you may be eligible for the Financial Assistance Program, you may request an application at the hospital business office, registration office, clinic office, or online at www.imhcc.com.

A written determination of your eligibility will be provided within 30 days of receipt of the completed application with all necessary supporting documentation. To be eligible for 100% Financial Assistance, household income must be at or below the following Federal poverty guidelines. Households that fall above the Federal Poverty Guidelines, but below 200% may be eligible for Financial Assistance based on a sliding scale.

To be eligible for 100% Financial Assistance, household income must be at or below the guidelines following Federal poverty guidelines.

Household Size	***Income***

Add $5,500 for each additional family member

Households that fall above the Federal Poverty but below 200% may be eligible for financial Assistance based on a sliding scale.

Household Size	***Income***

Add $11,000 for each additional family member

FINANCIAL ASSISTANCE APPLICATION

Applicant (Guarantor) Information:

Name: _____

Address: _____

City/State/ZIP: _____

Phone Number: _____ **Social Security Number:**_____-_____-_____

Account(s) for which assistance is being requested:

Date of Service	*Account #*	*Patient Name*	*Amount*
		TOTAL	

Have you filed taxes, or were you claimed as a dependent in the past 2 years?

If so, attach a copy of all pages of the return with all W2s or 1099s. ☐ **Yes** ☐ **No**

Do you or anyone in the household run a small business, farm, or ranch?

If so, attach income statements and balance sheets for the previous 3 months. ☐ **Yes** ☐ **No**

Household Size:

(must be able to provide legal proof of member in household: i.e. tax return, court documents, marriage license, etc.)

Name	Relationship to Applicant	Date of Birth	Income Source

Total

Household Income: (ALL household income must be reported) **Expenses:**

Type	Monthly Amount	Annual Amount
Applicant gross wages		
Spouse gross wages		
Social security		
Pension/VA/Railroad Retirement		
Workers Compensation		
Unemployment		
Child support/ Alimony		
Investments Income		
Other:		
Total:		

Type	Monthly Amount	Annual Amount
Rent/Mortgage		
Utilities		
Groceries		
Insurance		
Clothing		
Auto-gas/oil/repairs		
Medical/Dental		
Other		
Other		
Total:		

Assets	Value
Cash on hand	
Bank Name:	
Checking account balance:	
Savings account balance:	
Cash Value of Life Insurance	
Do you own your home?	Circle one YES NO
Home market value	
Automobiles/RVs/ATVs:	
Other Investments:	
Personal and Misc.	
Total	

Liabilities	
Home Mortgage Balance:	
Other Real Estate Balance:	
Credit Card/Loan Balances:	
Medical/Dental Balances:	
Other Debt:	
Total	

Net Worth	
Total Assets	**$**
(minus) Total Liabilities	**$**
Net Worth	**$**

balance sheet when appropriate

I hereby request Memorial Hospital of Carbon County provide services tojmittelstet@digitalgroupllc.com me, or my family member, without charge, or at a reduced charge, as may be determined in processing this application. I represent under oath, that I am unable to pay for services requested, and that all of the information submitted is complete and accurate, and may be subject to verification and review by state, federal and other enforcement agencies as required by law. I agree to provide to Memorial Hospital of Carbon County such additional information, as may be reasonably required, in order to substantiate my income, financial position, and ability to pay for services provided. I agree to release to MHCC, their agents, and their employees from all liability arising out of their responsible efforts to verify the information I have provided as a part of this application. I understand that my credit report may be used to verify this information. If I am entitled to any action or settlement from third party payers, I will take any action necessary or requested by Memorial Hospital of Carbon County to obtain such assistance and will assign to MHCC and upon receipt, will pay MHCC all amounts recovered up to and the total amount of the outstanding balance on my account.

Signature: _____ Date: _____

NOTE: Application must be returned by _____ to ensure eligibility

HOSPITAL USE ONLY

Date Application Provided to Guarantor: _____ Date Returned: _____

Assistance Eligibility Level: _____% Assistance applied to account: $_____

Balance of accounts after assistance and established payment plan: $_____

Authorized Signature: _____ Date: _____