Ivinson MEMORIAL HOSPITAL
an affiliate of UNIVERSITY OF COLORADO HEALTH

For questions or assistance with this application, please call (307) 755-4389.

FINANCIAL ASSISTANCE APPLICATION

PATIENT NAME: ______________________________ *ACCOUNT NUMBER:* _____________ *DATE OF APPLICATION:* ___________

FINANCIAL OVERVIEW:

⇒ Ivinson Memorial Hospital provides limited assistance on hospital bills to those persons meeting the criteria set forth in our Financial Assistance Policy. This application applies only to bills for Ivinson Memorial Hospital.

⇒ Any additional bills from other facilities remain the patient's responsibilities. Additional providers include, but are not limited to: ER Physicians of Laramie, Advanced Medical Imaging, and Wyoming Pathology.
These bills are not part of this application process.

⇒ Elective services or quality of life procedures do not qualify for financial assistance. Please contact our office if you are interested in a payment plan.

⇒ ***You are responsible for payments on your balance until determination of your eligibility has been approved.*** Please continue to make monthly payments, as failure to make payments on your accounts may result in denial of you application and collection action.

⇒ **This application and all required documents must be returned by ______________________________.**
Please contact our office prior to the above date if you need an extension.

REQUIRED DOCUMENTS

Photocopies only, do not submit originals.

1. Social Security, SSI or SSD documents for the last 3 months.
   A. Payroll documents for the last 3 months.
   B. Unemployment payment stubs/letter.
   C. Workers Compensation payment stubs/letter.
   D. Pension or annuity receipts.
   E. Child support or alimony payments.
   F. D-Pass/Food stamp receipts.
   G. Approval/Denial of Medicaid eligibility may be required.
2. Copy of 2 most recent bank statements, both checking and savings. If self-employed, we require both personal and business account information.
3. Spouse/Significant Other financial documentation, if you live together. Joint incomes, whether married or not, are part of the complete financial overview.
4. Copy of the current year's income taxes.
5. Additional medical expenses. Please list the doctor clinic and/or medical facility as well as the total amount you owe.

RESPONSIBLE PARTY

Name:	Home Phone: ( ) –
Home Address:	Email Address:
City: State: Zip:	Are you employed? ☐ Yes ☐ No
Date of Birth: SSN: – –	Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced
Employer:	Business Phone: ( ) –
Employer Address:	Length of Current Employment:
City: State: Zip:	Position/Title:
Monthly Income/Net:	Monthly Income/Gross:

SPOUSE/SIGNIFICANT OTHER

Name:	Home Phone: ( ) –
Home Address:	Length At This Address:
City: State: Zip:	Are you employed? ☐ Yes ☐ No
SSN: – –	Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced
Employer:	Business Phone: ( ) –
Employer Address:	Length of Current Employment:
City: State: Zip:	Position/Title:
Monthly Income/Net:	Monthly Income/Gross:

HOUSEHOLD SIZE

Total Persons In Household:	Do Any Other Persons Contribute Financially To The Family?	☐ Yes ☐ No

Please List The Name And Age Of All Persons In The Household:

Name:		Age:	
Name:		Age:	
Name:		Age:	

MISCELLANEOUS INCOME PER MONTH

PUBLIC ASSISTANCE/FOODSTAMPS:	$	PENSION:	$
SOCIAL SECURITY:	$	RENTAL INCOME:	$
UNEMPLOYMENT COMPENSATION:	$	GRANTS:	$
WORKMAN'S COMPENSATION:	$	IRA:	$
SAVINGS/CHECKING:	$	OTHER:	$
CHILD SUPPORT/ALIMONY:	$	TOTAL INCOME PER MONTH:	$

ASSETS AND LIABILITIES

ASSETS	VALUE	LIABILITIES	EXPENSE PER MONTH
CHECKING ACCOUNT:		MORTGAGE/RENT	
SAVINGS ACCOUNT:		SECOND OR MULTIPLE MORTGAGES	
HOME:		BANK LOAN	
PROPERTY (ACRE, LOTS)		AUTO LOAN	
AUTO:		MEDICAL PAYMENTS	
MAKE MODEL YR		FOOD	
AUTO:		UTILITIES	
MAKE MODEL YR		OTHER:	
TRAILER/MOTORHOME		OTHER:	
MAKE MODEL YR		OTHER:	
CD/STOCKS/BONDS/MUTUAL FUNDS. LIFE INS			
TOTAL VALUE OF ASSETS:		TOTAL BALANCE OF EXPENSES:	

FINANCIAL ASSISTANCE QUESTIONS

Do you rent or own your home?	☐ Rent ☐Own
Do you have health insurance?	☐ Yes ☐ No
If so, why is it not available for this date of service?____________________	Date applied: ____________
If no, have you applied for Medicaid?	☐Yes ☐ No
If denied, reason for denial: ____________________	If denied, date: ____________
Have you applied for insurance through the Affordable Care Act?	☐ Yes ☐ No
If no, please indicate reason for lack of insurance coverage? ____________________	

ADDITIONAL INFORMATION AND COMMENTS

AFFIRMATION AND VERIFICATION

In completing this financial statement, I hereby affirm that the above statements are correct and complete. I give my consent to further verification by Ivinson Memorial Hospital or its agents.

Signature: ______________________________ Date:________________

Relationship (If other than a parent): ____________________ Date: ________________

Return Completed application to: Ivinson Memorial Hospital, Attn: Financial Counselor, 255 N. 30TH ST., LARAMIE, WY 82072