Ivinson MEMORIAL HOSPITAL
an affiliate of UNIVERSITY OF COLORADO HEALTH

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

STUDENT 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. Verification of enrollment from **registrar's office** of your university/college/trade school, including your estimated date of graduation **AND** copies of all loan/grant documentation. Must have at least **12** credit hours.
2. Approval/Denial of Medicaid eligibility may be required.

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:

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:

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: _____

Spouse/Significant Other Signature: _____ Date: _____

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