GUNNISON
VALLEY HEALTH

EXHIBIT C

Financial Assistance Application

FINANCIAL ASSISTANCE PROGRAM

Gunnison Valley Health (GVH) is committed to providing emergency and medically necessary care to patients who are uninsured or who have limited insurance (underinsured). You may qualify for financial assistance if you are unable to pay your bill, or if paying it would result in financial hardship.

GVH provides financial assistance to Gunnison, Hinsdale, and Saguache County Residents.
Our Financial Assistance Program provides emergent or medically necessary services at discounted rates for patients who apply for financial assistance and who qualify.

When applying for Financial Assistance and to expedite your request quickly, Gunnison Valley Health will require this application to be filled out along with minimal documentation outlined. This application must be completed with accurate information within 45 days. If for any reason the information is not provided in a timely manner, your application may be denied, in which case you may be expected to pay your bill in full.

Given the sensitive nature of these requests, all communication with the patient or patient guarantor's will be managed in a confidential and compassionate manner.

Should you have any questions, feel free to contact us at 970-642-4790 for English, or 970-641-7207 for Spanish, or send an email to financialcounselor@gvh-colorado.org.

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COMPLETING THIS FORM IS NOT A GUARANTEE OF ELIGIBILITY

If you do not complete this application packet or if you return it without the requested supporting documentation, we may be unable to determine whether you qualify for our Financial Assistance Program. In that case, you will be responsible for the full balance due on your account.

If you need help in completing this form or gathering the supporting materials, please contact the Financial Counselor at 970-642-4790 (English) or 970-641-7207 (Spanish)

REQUIRED DOCUMENTS:

To determine if you qualify for our Financial Assistance Program, please return the following supporting documentation with this completed packet:

- ☐ A copy of a photo ID (state driver's license/state ID) or other identification documents (passport, employee ID card, etc.) for all adult relatives applying for Financial Assistance.
- ☐ A copy of the most recent and active health insurance cards for all family members applying in the household.
- ☐ Last year's Form 1040 federal income tax return, with all Forms W-2 and/or 1099.
- ☐ Last two weeks of paystubs with year-to-date totals, or last two months of paystubs without year-to-date totals (if paid in cash without paystubs, provide written verification from employer).
- ☐ Proof of income from all other sources such as unemployment compensation, disability income, rental income, pensions, annuities, interest payments, wage and earning statement from Social Security office.
    - If self-employed – proof of income for the last two months from bank statements including deposits and withdrawals, ledger, profit and loss statements, or invoices and receipts.
- ☐ If you are currently receiving Social Security benefits, a copy of your "benefit amount" letter.
- ☐ Proof of residency such as a copy of a current utility bill, telephone bill, or cable television bill which includes your name, physical address, and service address.
- ☐ If you are a student, a list of the current semester's credits/classes and a copy of your student ID.
- ☐ Deductions (receipts/statements for bills paid) from the last 6 months such as health, dental, or vision premiums and/or bills paid, childcare, child support, alimony, or elder care.

NOTE: The name shown on the patient's photo ID must be the same name shown on paystubs and tax forms.

NOTE: Where parents of a minor patient are divorced or separated but share responsibility for the minor's medical care, each parent must complete a separate application.

Please return this completed application and the requested supporting documentation as soon as possible. An application will not be reviewed until all required supporting documentation has been provided.

Applications will be closed after 45 days of the start date.

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FINANCIAL ASSISTANCE APPLICATION

Date: _____

(PLEASE PRINT – BE SURE TO PROVIDE ALL REQUESTED INFORMATION)

I. PERSONAL INFORMATION

Personal information of applicant (or parent if applicant is a minor):

Name_____ Date of Birth _____
Last First MI

Address _____
Street City State Zip Code

Living at Address Since _____ Phone # (_____) _____

Marital Status: Single_____ Married_____ Divorced _____ Widow_____

Spouse's Name_____Date of Birth_____

Adult relative living in the household _____ Date of Birth_____

List family members (including parents, patient, and natural or adoptive siblings) living at above address.

FAMILY MEMBER'S LEGAL NAME	DATE OF BIRTH	AGE	RELATIONSHIP TO PATIENT
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

II. INSURANCE INFORMATION – please provide your most current insurance

	APPLICANT (OR PARENT, IF APPLICANT IS A MINOR)	APPLICANT'S SPOUSE
Do you have health insurance? (Y/N)		
If yes, name of health insurance plan:		
Medicare? (Y/N)		
Medicare Part D? (Y/N)		
Medicare Supplement? (Y/N)		
Medicaid? (Y/N)		
Previously had Medicaid (Y/N)		
If yes, Medicaid number		
Veteran's Benefits? (Y/N)		

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III. EMPLOYMENT AND INCOME INFORMATION

Employment information of APPLICANT (or parent, if applicant is a minor):

Employer_____Unemployed? (Y/N)_____Date of Unemployment_____

Business Address _____ _____
Street City State Zip Code

Phone # (_____) _____Does Employer Offer Health Insurance? (Y/N) _____
Monthly Gross Income _____
Date of Hire _____

Student (Y/N) ____ Name of School_____ Number of Credits This Semester _____

Note: Do you have other source of income: (Yes/No), If yes, please explain _____

Employment information of SPOUSE (if applicable):

Spouse's Employer _____ Unemployed? (Y/N) ____Date of Unemployment_____

Business Address _____ _____
Street City State Zip Code

Phone # (_____) _____ Does Employer Offer Health Insurance? (Y/N) _____
Monthly Gross Income _____
Date of Hire _____

Student (Y/N) _____ Name of School_____Number of Credits This semester _____

Note: Do you have other source of income: (Yes/No), If yes, please explain _____

Employment information of ADULT RELATIVE IN THE HOUSEHOLD (if applicable):

Employer_____Unemployed? (Y/N)_____Date of Unemployment_____

Business Address _____ _____
Street City State Zip Code

Phone # (_____)_____Does Employer Offer Health Insurance? (Y/N) _____
Monthly Gross Income _____
Date of Hire _____

Student (Y/N) ____ Name of School_____ Number of Credits This Semester _____

Note: Do you have other source of income: (Yes/No), If yes, please explain _____

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Hospital Discount Care additional information

What is your preferred method of contact (phone or email)? _____
Are you experiencing homelessness? (Y/N) _____
Are you a resident of or currently living in Colorado? (Y/N) _____
Are any applicants US citizens? (Y/N) _____
Are any applications Legal permanent Residents (have a Green Card)? (Y/N) _____ If yes, how long? _____
Are any applicants here on a Visa? (Y/N) _____
If yes, what kind of Visa and what are the dates? _____
Do you have refugee status (documented by the government)? (Y/N) _____
Are you or is anyone in your household pregnant? (Y/N) _____
Is anyone in your household under 19 years old? (Y/N) _____
Do you have a disability? (Y/N) _____
Do you receive federal disability income? (Y/N) _____
Are you getting help from the Colorado Indigent Care Program? (Y/N) _____

VII. CERTIFICATION

I certify that the information I have provided in this application and the required supporting documentation is true and correct to the best of my knowledge. I will apply for any federal, state or local assistance for which I may be eligible to help pay for my medical care. I understand that the information provided may be verified by Gunnison Valley Health, and I authorize Gunnison Valley Health to contact third parties to verify the accuracy of the information I have provided. I understand that, if I knowingly provide inaccurate or incomplete information in this application, I may be ineligible for financial assistance, any financial assistance granted to me may be reversed, and I will be responsible for the payment of my medical bills.

Applicant's Signature _____Date of Request_____

Your completed application and supporting documentation may be submitted by:

- **EMAIL** : financialcounselor@gvh-colorado.org
- **MAIL:** 711 N Taylor St, Gunnison, CO, 81230 | Attn: Financial Counselor
- **IN PERSON:** Gunnison Valley Health – South Entrance 711 N Taylor St, Gunnison, CO 81230
  Monday through Friday 8:00 am to 4:30 pm

- **QUESTIONS/CONTACT:** (970) 642-4790, (970) 641-7207 (Spanish)
  Monday through Friday 8:00 am to 4:30 pm

***** To ensure timely processing, please be sure to include all the required information from the checklist on the first page of this application *****
Applicants will be notified within 14 business days after submission of a complete application with all required supporting documentation.
Applications will be closed after 45 days.

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