SOUTHWEST
Health System, Inc.
Where Caring and Community Come Together

Dear Patient,

The following forms will be used with your application for the Financial Assistance Program with Southwest Health System, Inc.

Supporting documentation to verify financial status and family size are required. See page five (5) for a detailed list of documents we require to be able to process your application for financial assistance. If an item does not apply to you, write “not applicable” or “n/a”.

The Financial Coordinator will not process incomplete applications. Incomplete applications may render your account ineligible for financial assistance.

When you have completed the following forms and gathered all applicable documents from page five (5) please call one of the Patient Financial Counselors below to schedule an appointment.

The basis of the Financial Assistance Program is the truthful and accurate provision and submission of financial information from the patient and/or responsible party (ies). Patient and/or responsible party (ies) who intentionally misrepresent their household information will be automatically disqualified from any consideration whatsoever with regard to the program. Intentional misrepresentation determination is the sole right of Southwest Health System, Inc.

Please remember:

1. Fill out the following forms completely
2. Gather all applicable supporting documentation listed on page five (5)
3. Call the Patient Financial Coordinator for an appointment

Patient Financial
Coordinator
1311 N Mildred Road
Cortez, CO 81321
Phone: (970) 564-2131 Fax:
(970) 564-2134

Thank you,

Southwest Health System, Inc.
Patient Financial Services
1311 N Mildred Road
Cortez, CO 81321
Main Phone: (970) 564-2130

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Applicant:

Last Name	First Name	Middle Initial	Maiden Name	Marital Status
Physical Address		City	State	Zip
Mailing Address		City	State	Zip
Home Phone		Work Phone		Cell Phone

Fill out the below for yourself and all legal dependents. Generally, a legal dependent is someone you can claim on your Federal Income Tax Return.

RELATION TO THE APPLICANT	LAST NAME	FIRST NAME	MIDDLE INITIAL	BIRTH DATE (MM/DD/YYYY)	SOCIAL SECURITY NUMBER	IS THIS PERSON A FULL TIME STUDENT? (Y or N)	DOES THIS PERSON NEED FINANCIAL ASSISTANCE? (Y or N)
SELF							

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Please answer all of the following questions:

1. Have you applied for Medicaid or CHP+? ☐Yes ☐No
2. When did you apply for Medicaid or CHP+? Date: _____
3. What is the status of your Medicaid or CHP+ application? ☐Approved ☐Denied ☐Pending
4. Do you own your home? ☐Yes ☐No
5. Is anyone in the household pregnant? ☐Yes ☐No
6. Who in the household is pregnant? Name: _____
7. Is anyone in the household disabled? ☐Yes ☐No
8. Who in the household is disabled? Name: _____
9. Have disabled household members applied for disability benefits through Social Security? ☐Yes ☐No
10. Do household members over the age of 18 have the ability to work? ☐Yes ☐No
11. If household members over the age of 18 do not have the ability to work, why? _____
12. Is there third party healthcare coverage for any household members? ☐Yes ☐No
13. Specify type of third party healthcare coverage ☐Medicare ☐Medicaid ☐CHP+ ☐Insurance ☐Other
14. Have any household members received CICP or charity care before? ☐Yes ☐No
    a. If yes, list type: _____
15. Have you filed for bankruptcy? ☐Yes ☐No
16. If you filed for bankruptcy, where and when did you file for bankruptcy? _____
17. Do you expect your income to change within the next year? ☐Yes ☐No
18. If you expect your income to change, what kind of change do you expect? _____

Please list your monthly net income (after taxes) and your monthly expenses below:

INCOME:	Most Current Full Month	**EXPENSES:**	Most Current Full Month	**OTHER EXPENSES:**	Most Current Full Month
Salaries	$	Rent/Mortgage	$	Groceries	$
Self Employment	$	Electric	$	Restaurant Meals	$
Unemployment	$	Water/Sewer	$	Personal Care	$
SSI	$	Gas/Heating	$	Doctors, Dentists, etc.	$
SSDI	$	Telephone	$	Prescriptions	$
Retirment/Pensions	$	TV	$	Gas/Auto Expenses	$
Social Security	$	Household/Repairs	$	Child Care	$
Alimony	$	Student Loan	$	Other:	$
Child Support	$	Credit Cards	$	Other:	$
Public Assistance	$	Other Loan Payments	$	Other:	$
Food Stamps	$	Health Insurance	$	Other:	$
Other:	$	Car/Home Insurance	$	Other:	$
Other:	$	Life Insurance	$	Other:	$
Total Income	$	**Total Expenses**		**Total Other Expenses**	$

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The following documentation is required when applying for the Financial Assistance Program. Please bring an original of the documents listed below to your appointment. If something does not apply to you, write "not applicable" or "n/a".

INCOME:

- ☐ Most recent, complete Federal Income Tax Return and W-2 withholding statements
- ☐ One (1) month most recent, consecutive paycheck stubs OR a statement from the employer. The statement must include the employer name, address, phone number, tax ID number, hire date, rate of pay, and average hours worked per week
- ☐ Self Employment: Last full month Profit and Loss Statement and three (3) consecutive months gross deposits
- ☐ Unemployment income statements
- ☐ Disability compensation statements (ie. SSI, SSDI, other)
- ☐ Social Security Income (yearly benefits statements)
- ☐ Retirement and Pension benefit statements
- ☐ Public assistance notices such as Aid to the Needy and Disabled, TANF, LEAP, Food Stamps, WIC, etc
- ☐ Child Support Received
- ☐ Alimony Received
- ☐ If you have no income, and someone is supporting you, they must write a letter including their printed name, address, phone number and signature stating the type of support that is being provided
- ☐ Two (2) months most recent bank statements (i.e. checking, savings, money market, check/cash card, etc.)

EXPENSES:

- ☐ Child Support Paid for the past three (3) months
- ☐ Alimony Paid for the past three (3) months
- ☐ Most current vehicle loan statements for all vehicles (for CICP only)
- ☐ It is optional for you to bring medical, dental, vision and pharmacy statements. **The statements must include the provider name, address, phone number, date of service and any payments or adjustments applied**
- ☐ Health Insurance Premiums

OTHER INFORMATION REQUIRED:

- ☐ Medicare, Medicaid, CHP+ and other Health Insurance cards
- ☐ Vehicle registration for all vehicles (for CICP only)
- ☐ Colorado Driver's License or Colorado Identification for each member of the household over the age of 18 applying for financial assistance