Financial Assistance Application

Date: _____

Please answer all questions completely and to the best of your knowledge in order to prevent delaying this application. Copies of the following documents **MUST** be attached, or the application will be rejected as incomplete. An incomplete application or failure to return prior to the **30 day** expiration will result in a denial of the application.

- Completed application
- Written statement as to why financial assistance is needed
- Tax Returns and W-2's for all members of the household, or notification of non-filing
- Two months paystubs for all household members
- Proof of all forms of income for all household members
- Most recent three months bank statements, including savings accounts
- Proof of any government benefits including food stamps, unemployment, Social Security
- Letter of Support from person's assisting you if you have limited or no income
    - Additional documents may be required for supporting people upon request.
- **Medicaid Letter (approval/denial) for all household members**

Approval for financial assistance is based on your house hold size and income, even if you have health insurance. You must complete the application and provide all documents requested within 30 days from posted date in order to be eligible and qualify for charity. Please note that completion of this application is not a guarantee of approval. **Accounts in collections/bad debt do not qualify for charity**. If financial assistance is approved, all services that are performed within 6 months prior and 6 months after application approval date will qualify for charity. **Professional fees, such as physician, radiologist, anesthesiologist, and pathologist fees may not be covered by the charity program.**

Cody Regional Health's policy requires individuals to apply for Wyoming Medicaid before being considered for financial assistance. To apply for Wyoming Medicaid, call 855-294-2127 to speak to Medicaid Customer Service. The best time to call is between 7-8am and 4-5pm.

Return Completed applications to: CRH Patient Financial Services
Attn: PFS Financial Assistance
707 Sheridan Avenue
Cody, Wyoming 82414

If you need assistance or have questions, please feel free to call the Financial Advocate at **307-578-2549.**

Financial assistance provided by CRH is secondary to all Third Party Payers and other financial resources available to the patient. Examples include Medicaid and other federal, state, or county medical programs.

Patient Name: _____ Phone #:_____

Address: _____

Age: _____ Marital Status: _____ Date of Birth: _____

Section 1- Household & Employment Information

List all persons living in household

Name	Relationship/Age	Date of Birth

Was the visit to the hospital in any way related to an on-the-job injury or occupational disease? _____
If yes, please
explain_____

Current Employer: Patient: _____
Spouse: _____

Section 2-Monthly <u>Household</u> Income & Expenses

Wages:	$	Food Stamps:	$
Tips:	$	Retirement:	$
Alimony/Child Support:	$	Unemployment:	$
Social Security:	$	Pensions:	$
Farm/Self Employed:	$	Income from Rentals:	$
Worker's Comp.	$	Settlement Income:	$
Inheritance:	$	Native American Income	$
Other Income:	$		
Total Income:	$		

Monthly Expenses

House Rent/Payment:	$	Gas:	$	Car Insurance:	$
Food:	$	Water:	$	Medical Insurance:	$
Car Payment:	$	Garbage:	$	Home Insurance:	$
Car Operating Expenses:	$	TV Services/Internet:	$		
Phone:	$	Child Care:	$	**Total Expenses:**	**$**

Section 3- Assets & Liabilities

House/Land Value:	$	Automobile 1 Loan:	$
Savings Account :	$	Automobile 2 Loan:	$
Checking Account:	$	House/Real Estate Loan:	$
Automobile 1 Value:	$	Personal Property Loan:	$
Automobile 2 Value:	$	Credit Card Balances:	$
Stocks, Bonds, CD's, IRA's:	$	Medical Liability:	$
Retirement Funds/Pensions:	$	Real Estate Taxes:	$
Other Assets:	$	Other Liability (Specify)	$
Total Assets:	**$**	**Total Liabilities:**	**$**

Section 4- Applicant Other Than Patient

If applicant is deceased, please complete the following:

1. Date patient expired: _____
2. Have you applied for Medicaid for the patient? (Y/N)_____ All patients that apply for financial assistance **MUST** also apply for **Wyoming Medicaid**
3. Is there a surviving spouse? (Y/N) _____ If yes, name and address of surviving spouse:
   _____
   _____
4. Is there an estate? (Y/N) _____
5. Name of person(s) completing application: _____
6. Relationship to patient: _____

- I understand that Cody Regional Health may verify information by reviewing credit information and obtaining information from other sources to assist in determining eligibility for financial assistance or payment plans.
- I authorize Cody Regional Health to contact employers, financial institutions, state and federal agencies, and other third parties to verify the information I provided or to obtain additional information regarding my finances. I authorize any such entities to provide information to Cody Regional Health about my current assets, liabilities, credit, and other information as reasonably requested.
- I affirm that the above information is true and correct to the best of my knowledge. I understand if the financial information I give is determined to be false, the result may be denial of financial assistance, and I may be responsible for and expected to pay for services provided.
- I release Cody Regional Health and its representatives from any and all liability connected with the release of information.
- I agree that if approved for charity, to set up a payment plan within 30 days of approved charity on the balance remaining on accounts

Applicant Signature: _____ Date: _____
Signature of Spouse: _____ Date: _____

Last updated: 2/9/2023