SPECIAL FINANCIAL CONSIDERATION APPLICATION

Return to: Donna Cramer Ashley Regional Medical Center 150 West 100 North Vernal, Utah 84078 (435) 781 - 6859

INSTRUCTIONS FOR COMPLETING THIS APPLICATION

IN ORDER FOR A PATIENT TO BE CONSIDERED FOR SPECIAL FINANCIAL CONSIDERATION
THIS APPLICATION SHOULD BE COMPLETED IN FULL AND THE REQUESTED DOCUMENTATION ATTACHED.
THE FORM SHOULD BE RETURNED TO ASHLEY REGIONAL MEDICAL CENTER
TO THE ATTENTION OF THE REPRESENTATIVE NAMED ABOVE.
THE INFORMATION PROVIDED WILL BE VERIFIED
AND A PROPER DETERMINATION WILL BE MADE IN A TIMELY MANNER.

PLEASE PROVIDE THE FOLLOWING DOCUMENTATION TO OUR FACILITY

THIS APPLICATION COMPLETED IN ITS ENTIRETY,
A COMPLETE COPY OF SIGNED FEDERAL TAX RETURN WITH ALL SCHEDULES FOR CURRENT YEAR,
COPIES OF PAYROLL CHECK STUBS FOR THE PREVIOUS THREE MONTHS, AND
ANY/ALL OTHER DOCUMENTATION SUBSTANTIATING INFORMATION PROVIDED.

	RESPONSIBL	E PARTY INFOR	MATION		
RESPONSIBLE PARTY NAME				MARITAL ST	TATUS
ADDRESS			CITY	ST	ZIP
SOCIAL SECURITY NUMBER		BIRTHDATE_	P	HONE NUMBER	
EMPLOYER		PHO	ONE NUMBER	DATE OF	HIRE
ADDRESS			CITY	ST	ZIP
SPOUSE'S NAME		BIRTHDATE	SOCIAL SE	CURITY NUMBER	
SPOUSE'S EMPLOYER		PHO	NE NUMBER	DATE OF HIR	E
NUMBER OF CHILDREN IN THE HOME	THEIR A	GES			
**********		OFFICE USE ONL	.Y IBERS IN HOUSEHOLD	*******	******
PATIENT NAME	ACCOUNT NUMBER	BALANCE	DISCARGE DATE	RELATIONSHIP	

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INCOME INFORMATION	RESPONSIBLE PARTY	SPOUSE
MONTHLY WAGES (BEFORE DEDUCTIONS)		
MONTHLY ALIMONY/CHILD SUPPORT		
MONTHLY DISABILITY/ WORKERS COMP		
MONTHLY PENSION		
MONTHLY SOCIAL SECURITY		
MONTHLY DIVIDENDS/ INTEREST		
MONTHLY RENTAL INCOME		
MONTHLY ESTATE/ TRUST		
MONTHLY WELFARE/ PUBLIC ASSISTANCE		
MONTHLY FOOD STAMPS		
MONTHLY OTHER INCOME (PLEASE LIST)		
LESS FICA/ STATE/ FEDERAL TAXES		
LESS ANY OTHER DEDUCTION		
MONTHLY INCOME TOTAL		
COMBINED MONTHLY INCOME (Line 1, Page 4)		
HAVE YOU EVER FILED FOR BANKRUPTCY? YES NO YEAR DISCHARGE		*******
**************************************	********	*******
	RESPONSIBLE PARTY	SPOUSE
CASH/ CHECKING		
INVESTMENTS/ STOCKS/ BONDS		
SAVINGS		

LIFE INSURANCE

RESIDENCE

OTHER

***********	*******	*******	********
	MONTHLY EXPENSE INFORMATION	BALANCE DUE	MONTHLY PAYMENT
RESIDENCE PAYMENT (RENTOWN)	_		
OTHER REAL PROPERTY (LIST)	_		
ALIMONY/CHILD SUPPORT PAYMENT	_		
VEHICLE 1 PAYMENT (MAKE YEAR)	_		
VEHICLE 2 PAYMENT (MAKE YEAR)	_		
VEHICLE 3 PAYMENT (MAKE YEAR)	_		
RECREATION VEHICLE (LIST)	_		
OTHER VEHICLE (LIST)	_		
MONTHLY EXPENSE TOTAL	(Line 2, Page 4)		
**********		******	
*****************	MEDICAL EXPENSE INFORMATION	*****	• * * * * * * * * * * * * * * * * * * *
MEDICAL PROVIDER NAME		BALANCE OWED	MONTHJLY PAYMENT
	-		
MEDICAL EXPENSE TOTAL	. (Line 3, Page 4)		
**********	***********	******	*******
	THER CREDITOR EXPENSE INFORMATION		
NAME OF CREDITOR	TYPE OF LOAN	BALANCE OWED	MONTHLY PAYMENT
OTHER CREDITOR EXPENSE TOTAL	L (Line 4, Page 4)		
*************	**********	********	*******
	OTHER MONTHLY EXPENSE		
AUTOMOBILE (INSURANCE/ GASOLINE/ REPAIRS			
GROCERIES			
INTERNET/ TELEPHONE/ TELEVISION			
MEDICAL INSURANCE			
UTILITIES (ELECTRICITY/ GAS/ SEWER/ WATER)			
OTHER MONTHLY EXPENSE TO	OTAL (Line 5, Page 4)		

Page 3 o ***********************************
MONTHLY INCOME TOTAL (From Page 2)
MONTHLY EXPENSE TOTAL (From Page 3)
MEDICAL EXPENSE TOTAL (From Page 3)
OTHER CREDITOR EXPENSE TOTAL (From Page 3)
OTHER MONTHLY EXPENSE TOTAL (From Page 3)
NET MONTHLY INCOME

PLEASE PROVIDE ANY ADDITIONAL INFORMATION AFFECTING YOUR ABILITY TO PAY FOR SERVICES PROVIDED AT OUR FACILITY. ATTACH A SEPARATE SHEET IF NECESSARY.
HAVE YOU APPLIED FOR MEDICAID? YES NO IF YES AND YOU WERE DENIED OR FOUND TO BE INELIGIBLE, PLEASE EXPLAIN.
HAVE YOU ASKED FOR ASSISTANCE FROM YOUR FAMILY? YESNO EXPLAIN:
HAVE YOU ASKED FOR ASSISTANCE FROM YOUR CLERGY/CHURCH? YESNO EXPLAIN:
HOW MUCH ARE YOU ABLE TO PAY EACH MONTH? EXPLAIN:
A MINIMUM MONTHLY PAYMENT OF IS REQUIRED ON MY COMBINED ACCOUNTS.
WITH THIS APPLICATION I AM REQUESTING A LOWER MONTHLY PAYMENT OF
I HERBY STATE THAT THE INFORMATION I HAVE PROVIDED IS TRUE AND COMPLETE.
I AUTHORIZE ASHLEY REGIONAL MEDICAL CENTER TO VERIFY THIS INFORMATION, INCLUDING REQUESTING A CREDIT BUREAU REPORT.
I UNDERSTAND THAT IF ANY OF THIS INFORMATION IS DETERMINED TO BE DECEPTIVE OR FALSE, I MAY BE DENIED SPECIAL FINANCIAL CONSIDERATION AND I WILL BE LIABLE FOR PAYMENT OF ANY AND ALL CHARGES INCURRED FOR SERVICES RENDERED.
RESPONSIBLE PARTY'S SIGNATUREDATE