Ashley Regional Medical Center

150 West 100 North
Vernal, Utah 84078

DATE RECEIVED____________RECEIVED BY______________

INSTRUCTIONS FOR COMPLETING THIS FORM

In order for a patient to be considered for special financial consideration, this form should be completed and the requested documentation attached, and the form returned by _____________(date) .The information will be verified and a proper determination will be made in a timely manner. Please provide the following documentation to the facility. If this information is not received the application will be denied.

1. ___***This form, completed in its entirety.***
2. ___***Complete copies of signed Federal Tax Return with all schedules (For the most recent year).***
3. ___***Copies of payroll check stubs for the previous (3) months.***
4. ___***Copies of 3 current monthly statements and receipts of all listed out- going expenses.***
5. ___***Current bank statement.***
6. ___***Letter explaining your financial hardship. (why you need assistance)***

RESPONSIBLE PARTY INFORMATION

Responsible Party Name: ____ Marital Status: ______________

Address: _______________________________ City: ________________ St: _______ Zip: ________________

Social Security #: ________________________ Birth Date: _______________ Phone #: __________________

Employer: ______________________________ Phone #: ________________ Date of Hire: ________________

Address: _______________________________ City: ________________ St: _______ Zip: ________________

Spouse's Name: _________________________ Birth Date: ______________ SSN #: ____________________

Spouse's Employer: _________________________ Phone #: __________ Date of Hire: ______________

Number of Children in the Home: ________________ Their Ages: ____________________________________

FOR OFFICE USE ONLY
List Account Information for Members in Household:
(For Additional Members - Attach a Separate Sheet if Necessary)

Patient Name:	Account #:	Balance:	Age:	Relationship:

MONTHLY INCOME INFORMATION

Income Sources **(W-2 form, income tax statement, check stubs, or check statements are required for verification. A financial statement may be required if you are self-employed.)**

	Responsible Party	Spouse
	Must have 3 current months of statements for both	
Wages (Before Deductions)	$ ________________	$ ________________
Alimony / Child Support	$ ________________	$ ________________
Disability / Worker's Compensation	$ ________________	$ ________________
Pension	$ ________________	$ ________________
Social Security Income	$ ________________	$ ________________
Dividends / Interest / Income	$ ________________	$ ________________
Rental Income	$ ________________	$ ________________
Estate / Trust Income	$ ________________	$ ________________
Welfare / Public Assistance	$ ________________	$ ________________
Food Stamps	$ ________________	$ ________________
Other (Please List)	$ ________________	$ ________________
Less FICA/State/Federal Taxes	$ ________________	$ ________________
Less Any Other Deductions	$ ________________	$ ________________
MONTHLY INCOME TOTALS:	$ ________________	$ ________________

Have you ever filed Bankruptcy? Yes ______ No ______ Year: 19______

ASSETS	Value		Value
Must have 3 current months of statements			
Cash / Checking	$ ________________	Investments	$ ________________
Savings	$ ________________	Life Insurance	$ ________________
Stocks / Bonds	$ ________________	Other	$ ________________

MONTHLY PAYMENTS

ALL REAL PROPERTY/VEHICLES		Balance Due	Monthly Payment
Must have 3 current months of statements			
Residence (Own ___ Rent ___)		____________	____________
Other Real Property (List) ________________		____________	____________
Vehicle #1: Make ____________		____________	____________
Model: ____________	Year: ____________		
Vehicle #2: Make ____________		____________	____________
Model: ____________	Year: ____________		
Recreation Vehicle: ____________		____________	____________
Model: ____________	Year: ____________		
Other Vehicle: ____________		____________	____________
Model: ____________	Year: ____________		

MONTHLY PAYMENTS CONTINUED—*Must have 3 current months of statements*

Medical Expenses

Hospital / Physician Name / Pharmacy	Balance Due	Amount Insurance Will Pay	Monthly Payments

List All Other Creditors ***–Must have 3 current months of statements***

(Charge Cards, Mail Order, Gas Cards, etc. - Attach a separate sheet if necessary)

Name of Creditor	Type of Loan	Balance Due	Monthly Payments
Appliance Furniture Rental:			
Other:			

Other Monthly Expenses ***3 current months of statements***

Monthly Payment

Food . . . . ____________

Must have 3 currently months of statement for all below

Auto Insurance

6 months $______ ____________

Gasoline . . . . ____________

Health Insurance _______

(If not deducted from payroll) . . . . ____________

Prescriptions . . . . ____________

Utilities:

Heating Fuel . . . . ____________

Phone . . . . ____________

Water / Garbage . . . . ____________

Electrical . . . . ____________

Cable TV . . . . ____________

Contributions . . . . ____________

Other (List):

____________ ____________

PAYMENT SUBTOTALS: $____________

Monthly Financial Summary

TOTAL INCOME: $ ____________

SUBTOTALS:

Real Property / Vehicles $ ____________

Monthly Medical Expenses $ ____________

Revolving Credit $ ____________

Other Monthly Expenses $ ____________

TOTAL EXPENSES $ ____________

- Have you applied for Medicaid and been denied or found to be ineligible? If so, attach denial.
  Yes _______ No ________
- Children present in home? Yes_________ No________

IF NO IS CHECKED, THE APPLICATION IS DENIED unless no children are present in home.

- Have you asked for assistance from your family? Yes _______ No ________

IF YES, WHAT WAS THE OUTCOME

____

IF NO IS CHECKED APPLICATION IS DENIED

- Have you asked for assistance from your clergy / church? Yes _______ No ________

IF YES, WHAT WAS THE OUTCOME

____

IF NO IS CHECKED, THE APPLICATION IS INCOMPLETE. MUST STATE WHY YOU DID NOT ASK FOR ASSISTANCE

- How much are you able to pay each month? $ _____________________________(If there is no amount listed here we will not be able to process this application, no account is written off at 100%. Monthly payments **must** be made during the time this application is being processed)

I hereby 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 any and all charges incurred for services rendered.

[ ] ____ __________________________
Responsible Party's Signature Date

FOR OFFICE USE ONLY

APPROVAL SIGNATURES AND COMMENTS

____ __________________________
Financial Counselor Date

____ __________________________
Patient Financial Services Director / Manager Date

FACILITY COMMENTS: ____

____

____

Total Charges: $_______________ Insurance Payments: ________________ Patient Payments:____________________

Financial Consideration: ____________________________ Total Balance Due: ____________________