Financial Assistance Application

For questions or assistance completing this application, call (307) 755-4389

Patient Name:_____ Account #:_____ Date of Appl.:_____

Ivinson Memorial Hospital provides limited assistance on hospital bills to those persons meeting the criteria set forth in our Financial Assistance Policy. This application applies only to bills for Ivinson Memorial Hospital.

Elective services or quality of life procedures do not qualify for financial assistance. Please contact our office if you are interested in a payment plan.

You are responsible for payments on your balance until determination of your eligibility has been approved. Please continue to make monthly payments, failure to make payments on your accounts may result in denial of your application and collection action.

This application and all required documents must be returned by _____. Please contact our office prior to the above date if you need an extension.

Required Documents: Photocopies only, do not submit original documents.

1. Social Security, SSI or SSD documents for the last 3 months.
   a. Payroll documents.
   b. Unemployment payment stubs/letter.
   c. Workers Compensation payment stubs/letter.
   d. Pension or annuity receipts.
   e. Child support or alimony payments.
   f. D-Pass/Food stamp receipts.
   g. Approval/Denial of Medicaid eligibility may be required.
2. Copy of 2 most recent bank statements, both checking and savings. If self-employed, we require both personal and business account information.
3. Spouse/Significant Other financial documentation, if you live together. Joint incomes, whether married or not, are part of the complete financial overview.
4. Current year's income taxes.
5. Additional medical expenses. Please list the doctor, clinic and/or medical facility as well as the total amount you owe.

Responsible Party:

Name:_____

Home Address:_____

City:_____ State:_____ Zip:_____

Date of Birth:_____ SSN:_____

Home Phone:_____

Email:_____

Marital Status: ☐Single ☐Married ☐Widowed ☐Divorced

Are you employed? ☐Yes ☐No

Employer:_____

Employer Address:_____

City:_____ State:_____ Zip:_____

Business Phone:_____

Length of Current Employment:_____

Position / Title:_____

Monthly Income/Net:_____

Monthly Income/Gross:_____

Spouse / Significant Other:

Name:_____

Home Address:_____

City:_____ State:_____ Zip:_____

Date of Birth:_____ SSN: _____

Home Phone:_____

Email:_____

Marital Status: ☐Single ☐Married ☐Widowed ☐Divorced

Are you employed? ☐Yes ☐No

Employer:_____

Employer Address:_____

City:_____ State:_____ Zip:_____

Business Phone:_____

Length of Current Employment:_____

Position / Title:_____

Monthly Income/Net:_____

Monthly Income/Gross:_____

Total Persons in Household:_____ Do any other persons contribute financially to the household? ☐Yes ☐No

Please list the name and age of all persons in the household:

Name	Age	Name	Age	Name	Age

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Miscellaneous Income Per Month

Public Asst. / Food Stamps	$	Pension	$
Social Security	$	Rental Income	$
Unemployment Comp.	$	Grants	$
Worker's Comp.	$	IRA	$
Savings / Checking	$	Other	$
Child Support / Alimony	$	Total Income Per Month	$

Assets and Liabilities

Assets	**Value**	**Liabilities**	**Expense Per Month**
Checking Account		Mortgage/Rent	
Savings Account		Second or Multiple Mortgages	
Home		Bank Loan	
Property (Acre, Lots)		Auto Loan	
Auto Make Model Year		Medical Payments	
		Food	
Auto Make Model Year		Utilities	
		Other	
Trailer/Motor Home Make Model Year		Other	
		Other	
CD/Stocks/Bonds/Mutual Funds, Life Insurance			
Total Value of Assets		Total Balance of Expenses	

Do you rent or own your home? ☐Rent ☐Own

Do you have health insurance? ☐Yes ☐No

If yes, why is it not available for this date of service?_____

_____

_____

Date Applied:_____

If no, have you applied for Medicaid? ☐Yes ☐No

If denied, date of denial:_____

If denied, reason for denial:_____

_____

_____

Have you applied for insurance through the Affordable Care Act? ☐Yes ☐No

If no, please indicate reason for lack of insurance coverage:____

_____

_____

Additional Information and Comments:_____

_____

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_____

Affirmation and Verification: By completing this financial statement, I hereby affirm that the above statements are correct and complete. I give my consent to further verification by Ivinson Memorial Hospital or its agents.

Signature:_____ Date:_____

Relationship (if other than a parent):_____

Return completed application to: Ivinson Memorial Hospital, Attn: Financial Counselor, 255 N 30th St, Laramie, WY 82072