Ivinson MEMORIAL HOSPITAL
AN AFFILIATE OF UCHealth

Student 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, as 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. **Verification of Enrollment** from **registrar's office** of your university/college/trade school, including your estimated date of graduation AND copies of all loan/grant documentation. **You must have at least 12 credit hours.**
2. **Approval/Denial of Medicaid eligibility may be required.**

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:_____

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:_____

Additional Information and Comments:_____

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):_____ Date:_____

Spouse/Significant Other Signature:_____ Date:_____

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