GUNNISON VALLEY HEALTH

Title: Gunnison Valley Hospital and Family Medicine Clinic Financial Assistance Policy

Original Approval Date: 07/2003	Last Reviewed/Revised Date: 11/01/2021
Approval by: Policy Manager, Director of Care Management	

Summary:

This policy and procedure establishes a framework for the Patient Financial Services Department to identify patients that may qualify for financial assistance and administer the program in accordance with the hospital's policy. There will be no discrimination based on race, color, creed, religion, gender, sexual orientation, citizenship, age disability or national origin.

Scope:

Gunnison Valley Hospital and Family Medicine Clinic (GVH & FMC) are committed to providing emergency and medically necessary care to patients who are uninsured or who have limited insurance (underinsured). You may qualify for financial assistance if you are unable to pay your bill, or if paying it would result in financial hardship. GVH and FMC provides financial assistance to Gunnison, Hinsdale and Saguache County Residents.

The Financial Assistance Program (FAP) covers emergency and medically necessary services provided by GVH and FMC. GVH and FMC reserves the right to exclude or limit non-urgent, elective or not medically necessary services from the FAP.

This written policy:

- Includes Eligibility Criteria
- Defines the method by which patients may apply for financial assistance
- Defines the process for calculating discounted amounts to eligible patients
- Defines how the hospital will publicize the policy within the community served by the hospital

Policy:

Gunnison Valley Hospital and Family Medicine Clinic are committed to excellence in providing quality healthcare and meeting the healthcare needs of the community it serves. GVH and FMC provide financial assistance to our residents and individuals who qualify, as outlined in the Financial Assistance Discount Scale in Exhibit A and the Federal Poverty Level in Exhibit B. The Financial Counselor will administer the FAP according to the GVH and FMC Policy.

I. Eligibility

You may be eligible for financial assistance for emergency or medically necessary healthcare services, if your family income is at or below 400 percent of the federal poverty guidelines, as published annually. See Federal Poverty Level Exhibit B.

The FAP will provide benefits as a last resort. All other payment options, including but not limited to private insurance, Medicare, Medicaid, CHP, Third party Liability, and CICP must be explored for eligibility and secured where eligible prior to the application for financial assistance.

Eligible accounts include Gunnison Valley Hospital and Family Medicine Clinic (GVH & FMC) accounts with remaining balances. Accounts turned to bad debt will be considered as long as the complete application and supporting documentation are submitted prior to 180 days from the date of the initial account statement.

Patients, or patients' guarantors, who do not cooperate in applying for programs that may pay for their health care services such as Medicaid, may be denied financial assistance. GVH and FMC shall make all efforts to assist a patient or patient's guarantor to apply for public and private programs.

II. **Provider**s

The following locations and providers are all covered under Gunnison Valley Health's Financial Assistance Program.

Gunnison Valley Health*

Gunnison Valley Health Emergency Room Physicians

Gunnison Valley Health Hospitalist Physicians

Gunnison Valley Health Mountain Clinic

Gunnison Valley Health Urgent Care

Gunnison Valley Health Family Medicine Clinic

Gunnison Valley Health General Surgery Clinic

Any other physician or provider of care at Gunnison Valley Health not listed above is not subject to the Financial Assistance Program.

**Some non-urgent, elective or not medically necessary services are excluded from or limited in the Financial Assistance Program*

III. Medical Hardship

While financial assistance is typically provided in accordance with the established criteria, it is recognized that there may occasionally be a need for granting additional support based on extenuating circumstances.
For eligible services, discounted care will be provided to a patient, or patient's guarantor, meeting the following criteria:

- Patient, or patient's guarantor, has annual family income in excess of 400% of the Federal Poverty Guidelines, but less than $200,000, and
- Patient, or patient's guarantor, has exhausted all other payment options including private coverage, federal, state and local medical assistance programs, and other forms of assistance provided by third-parties; and
- The out-of-pocket, patient obligations resulting from medical services provided by GVH and FMC providers exceed 20% of annual family income.

In addition, financial assistance may be provided in other circumstances on a case-by-case basis as determined by The Revenue Cycle Director and Chief Financial Officer at their discretion.

Definitions:

Amounts Generally Billed: (AGB) means the amounts generally billed for emergency or other medically necessary care.

Discount: Patients may qualify for a financial assistance discount based on the patient's federal poverty level and medical services provided. Defined in the Financial Assistance Program Discount Scale in Exhibit A.

Duration of Eligibility: Once approved for financial assistance, eligibility is valid for 6 months from the application date. After 6 months, you must reapply for the FAP and resubmit all supporting documents.

Eligibility Criteria: The period during which applications for financial assistance are accepted. Financial assistance will be considered as long as the complete application and supporting documentation are submitted prior to 180 days from the date of the initial account statement.

Family: The patient, his or her spouse (including a legal common-law spouse), any minor children supported by the patient, and any adults for whom the patient is legally responsible. In the case of a minor patient, family includes both parents, the spouse of a parent, minor siblings, and any adults for whom the patient's guarantor is legally responsible. A pregnant female counts as two family members.

Family Income: The sum of a family's annual earnings and cash benefits from all sources before taxes, less payments made for child support. Family income includes gross wages, salaries, dividends, interest, Social Security benefits, workers' compensation, veterans' benefits, unemployment compensation, survivors benefits, regular support from family members not living in the household (other than child support), government pensions, private pensions, insurance, annuity payments, income from rents, royalties, estates, trusts, and other forms of income.

Federal Poverty Guidelines: Federal Poverty Guidelines are updated annually in the Federal Register by the United States Department of Health and Human Services under authorize of subsection (2) of Policy Reference #:4140, Version# 2 3 Section 9902 of Title 42 of the United States Code. Current guidelines can be referenced at https://aspe.hhs.gov/poverty-guidelines. See Federal Poverty Level Exhibit B

Financial Assistance: Either full or partial discount to patients for emergency or medically necessary care, in the case of patients who are Financially Eligible or Presumptively Eligible, as those terms are defined in this policy. Financial assistance may include co-payments, deductibles, or both.

Guarantor: As applicable depending on context, either the patient or his or her guarantor, *i.e.*, the person having financial responsibility for payment of the account balance.

Medically Necessary Care: Means health care services that a physician would provide to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease or its symptoms in a manner that is:

A. in accordance with generally accepted standards of medical practice;
B. clinically appropriate in terms of type, frequency, extent, site and duration; and
C. CMS medically approved services

Physical Therapy and Behavioral Health are limited to six visits based on medical necessity.

Non-Covered Services: Gunnison Valley Hospital and Family Medicine Clinic reserves the right to exclude or limit non-emergency hospital services from the FAP. Services not included are cosmetic surgery, ophthalmology, integrative therapies, and oncology.

Presumptive Eligibility: There are instances when a patient may qualify for financial assistance; however, a full application is not on file. Certain circumstances provide sufficient information to qualify the patient for financial assistance without the fully completed application, and are deemed presumptively eligible.

- Homelessness
- Deceased with no estate
- Medicaid eligible, but not active for a date of service. 90 day look back period
- Mental incapacitation: No one to act on patient's behalf
- Patient is eligible for out-of-state Medicaid and GVH and FMC does not participate in the States Medicaid Program.

Reasonable Payment Plan: A payment plan that is negotiated between GVH and FMC and the guarantor for any balances owed. The payment plan shall take into account the patient, or guarantor's income and assets, the amount owed and any prior payments.

Procedure:

The Customer Service Supervisor will ensure that the Financial Counselor is competent and knowledgeable in all matters related to the Financial Assistance Policy at GVH and FMC and is able to accurately process and administer the Financial Assistance program.

I. Applying for Financial Assistance

The Financial Counselor will make financial assistance eligibility determinations based on GVH and FMC policy, and an assessment of the patient, and or the patient's guarantor financial need.

GVH and FMC will make information readily available of its financial assistance polices or programs and will be posted on the GVH website. Notices on the availability of financial assistance will be posted in emergency

departments, urgent care centers, registration departments and patient financial services office, and at other locations that GVH and FMC deems appropriate.

A request for financial assistance may be made by a patient, a patient's guarantor, a family member, a close friend or associate of the patient, subject to applicable privacy laws. GVH and FMC will also respond to any oral or written requests for more information on the financial assistance program or policy.

Patients, or patients' guarantors, have a responsibility to cooperate in applying for financial assistance by providing information and documentation on family size, income and assets.

II. Application and Documentation

Patients seeking financial assistance will be required to complete the Financial Assistance Application, see Exhibit C.

Copies of the Financial Assistance Application are available at the Financial Counselor office, Customer Service, any GVH and FMC registration areas, and at our website at www.GunnisonValleyHealth.org.

All applicants must complete the GVH and FMC Financial Assistance Application and provide the supporting documentation as referenced in the application.

Applications may be completed directly by the patient, by the patient's guarantor and/or other legal representative. The Financial Counselor may complete the application based on information derived from an interview either in person, by telephone, or reliable information provided in writing. If assistance is needed with gathering necessary information or materials requested as part of the financial assistance qualifying process, patients are encouraged to contact the Financial Counselor at 970-642-4790. The Financial Counselor may also assist patients with assessing their financial situations, gathering information requested by GVH and FMC, and assisting with similar tasks.

Our Financial Counselor is available to assist patient, or guarantors through the Financial Assistance Application process. The Financial Counselor can be reached in the following ways:

- **PHONE:** (970) 642-4790, Monday through Friday 8:00 am to 4:30 pm
- **EMAIL**: FinancialCounselor@gvh-colorado.org
- **MAIL:** 711 N Taylor St, Gunnison, CO, 81230 | Attn: Financial Counselor
- **IN PERSON:** Gunnison Valley Hospital – South Entrance 711 N Taylor St, Gunnison, CO 82130, Monday through Friday 8:00 am to 4:30 pm
- **SCHEDULE AN APPOINTMENT** (970) 642-4790

III. Financial Screening

At the time of the initial patient, or guarantor interview, the Financial Counselor or Customer Service Representative will screen patient, or guarantors who are advising they are in need of financial assistance or they do not have the means to pay.

The representative will gather routine demographic, financial and existing third party coverage information.

GVH and FMC will first make reasonable efforts to explain the benefits of Medicaid and other available public and private programs to patients, or patients' guarantors, and make available to them information on those programs that may provide coverage for services.

If it is determined that GVH or FMC could potentially qualify the applicant for financial assistance or the Colorado

Indigent Care Program, accounts will be placed on a 14-business day hold while the applicant completes the application and provides the required documentation.

If the patient, or guarantor refuses to apply for or provide information necessary to the application process, he or she may be ineligible for financial assistance pursuant to this policy.

IV. Medicaid Screening

During this screening process, the Financial Counselor will calculate the applicants Federal Poverty Level. Based on the patient, and or patients guarantors Federal Poverty Level, it may be determined that the applicant must first apply for Colorado State Medicaid in order to be considered for assistance at GVH and FMC. Patient, or guarantors must apply for Colorado State Medicaid either online or at DHS in Gunnison. Accounts will be placed on a 30-day hold until Medicaid determination is made.

For more information, please contact our local Department of Health and Human Services or visit their website.

- **WEBSITE:** https://www.healthfirstcolorado.com/apply-now/
- **IN PERSON: Local DHHS** 220 N Spruce St, Gunnison, CO 81230
- **APPLY BY PHONE:** Call 1-800-221-3943/ State Relay: 711

V. Income Determination

To be eligible for financial assistance, gross personal and business income must be accurately determined for all family and legally responsibility parties. Financial assistance is offered to Gunnison, Hinsdale and Saguache Residents who are at or below the 400% Federal Poverty Level (FPL), as published on a yearly basis. See Federal Poverty Level, Exhibit B.

Gunnison Valley, Hinsdale and Saguache Residents who are at or below 250% FPL will be required to apply for The Colorado Indigent Care Program (CICP), as administered by Gunnison Valley Hospital and Family Medicine Clinic.

Family Income determines Federal Poverty Level. The sum of a family's annual earnings and cash benefits from all sources before taxes, less payments made for child support. Family income includes gross wages, salaries, dividends, interest, Social Security benefits, workers' compensation, veterans' benefits, unemployment compensation, survivors benefits, regular support from family members not living in the household (other than child support), government pensions, private pensions, insurance, annuity payments, income from rents, royalties, estates, trusts, and other forms of income.

VI. Income Verification

The preferred method of verifying income is through the most recent IRS form W-2, if self-employed your most recent tax return.

If you are unable to provide GVH and FMC with a W-2 or if your financial situation has changed from last year, Two (2) or more of the following may be used to verify income:

- Wage/earning statement
- Last three (3) of your most recent paycheck stubs
- Business profit/loss statement
- Three (3) months' worth of Checking and Saving statements for all family members
- Unemployment compensation letter accompanied with checking and savings account
- Notarized letter from employer of a statement of earnings, this must be on company letterhead and signed by the owner of the business

- If you do not have a source of income, provide a written statement explaining how monthly expenses are being met

VII. Establishing and Notification of Financial Assistance Eligibility

Application for financial assistance will be considered if the complete application and documentation is submitted prior to 180 days from the date of the initial account statement.

Determination for financial assistance will be made after all efforts to qualify the patient, or guarantor for other public or private programs have been exhausted. If the patient and or patient guarantor is pursuing other public or private programs, GVH and FMC will cease collection efforts while such determination is being made.

Within 15 business days after submission of a completed Financial Assistance Application, GVH and FMC will determine whether the patient qualifies for financial assistance based on eligibility as outlined in the policy. If the application is approved for financial assistance, GVH and FMC will notify the patient or patient's guarantor in writing of such determination and the amount of the discount to be provided. In the event that GVH and FMC determines a patient, or guarantor not to qualify for financial assistance, the Financial Counselor will notify the patient, and or patient's guarantor in writing of such determination. The notice will include the basis for the denial and instructions for reapplying if the patient's financial circumstances have changed.

If eligibility is approved, the patient, or guarantor will be granted financial assistance for a period of six months following the date of the completed Financial Assistance Application. Financial assistance will also be applied to all eligible accounts incurred for services received for the next six months or 90 days prior to the completed application date.

You must reapply for financial assistance after the eligibility term has expired. During the eligibility term, the patient, or patient's guarantor, may re-apply whenever there has been a change of income or status.

If GVH and FMC contacts the patient, or guarantor to request missing information, the patient, or guarantor will have a period of 30 days to respond. Failure to respond within that 30-day period will result in the Application being denied. The patient, or guarantor may re-activate the Application by providing the requested information at any time during the 180-day period following the initial account statement.

If an applicant provides information that is inaccurate or misleading, the application may be deemed ineligible for financial assistance and the patient, and or patient guarantor may be expected to pay the bill in full.

VIII. Appeals and Dispute Resolution

Patients or patient's guarantor may seek a review from GVH and FMC in the event of a dispute over the outcome of their application. Patients or patient's guarantor denied financial assistance may appeal their eligibility determination.

The basis for the dispute and appeal should be filed in writing and submitted within 30 days of the FAP eligibility notice along with any additional documentation supporting the dispute or appeal to the Customer Service Supervisor. The Customer Service Supervisor will do an internal review and respond in writing within 14 days.

- **MAIL:** 711 N Taylor St, Gunnison, CO, 81230 | Attn: Customer Service Supervisor
- **EMAIL:** CustomerService@GVH-Colorado.org
- **IN PERSON:** Gunnison Valley Hospital – South Entrance 711 N Taylor St, Gunnison, CO 82130, Monday through Friday 8:00 am to 4:30 pm

IX. Discounts:

Financial assistance discounts will be posted after the Customer Service Supervisor approves the Financial Assistance Application. The patient, or guarantor will receive a new statement with an updated balance after the FAP discount is posted on the account(s).

Payment is expected in full within 30 days of the new statement date after the FAP discount has been posted.

Hospital FAP discounts receive the appropriate level of approval:

- Financial Counselor is approved to post FAP discounts ranging from $1.00-$1000.99
- Customer Service Supervisor is approved to post FAP discounts ranging from $1001-$5,000.99
- Revenue Cycle Director is approved to post FAP discounts ranging from $5,001.00- $10,000
- Chief Financial Officer must approve any adjustment greater than $10,000.00

X. Amounts Generally Billed

If a patient qualifies for financial assistance under this policy, the patient's billed charges will be no more than the same amounts generally billed (AGB) for emergency or other medically necessary health care services as patients who have insurance coverage.

Gunnison Valley Health's AGB percentage is 71% of gross charges for inpatient and outpatient services.

This percentage is based on all claims allowed for Gunnison Valley Health emergency and other medically necessary inpatient and outpatient services by Medicare, Medicaid and private payers over a 12-month period divided by the associated gross charges for those claims.

XI. Collection Procedures

Any patient eligible for discounting will be required to pay their copay or percentage due upon determination of their eligibility, or they must sign an approved payment plan contract.

Gunnison Valley Hospital and Family Medicine Clinic may pursue collection actions against patients found ineligible for financial assistance, patients who received discounted care or medical hardship discounts but are no longer cooperating in good faith to pay the remaining balance, or patients who have established payment plans but are not in accordance with the payment plan.

During the Notification Period (120 Days), the Hospital will provide each patient with at least three Billing Statements, a Seriously Past Due notice, and a Final notice that provides the individual with the amount owed. The hospital may initiate External Collection Activity (ECA), but only after the Final notice letter has been provided and a period of at least 30 days have elapsed.

Patients who qualify for financial assistance under the Gunnison Valley Health Financial Assistance Policy, but who fail to pay the remaining (discounted) balance when due, are considered uncollectible bad debts for the amount of such balances; such accounts will be referred to outside agencies for collection.

XII. Confidentiality:

The Hospital recognizes that the need for financial assistance may be a sensitive and deeply personal issue for patients, or guarantors. Confidentiality of information and preservation of individual dignity will be maintained for all who seek financial assistance pursuant to this Policy. No information obtained in the patient's Financial Assistance Application may be released, except where authorized by the patient.

Exhibits:

Exhibit A FINANCIAL ASSISTANCE PROGRAM DISCOUNT SCALE

Exhibit B FEDERAL POVERTY LEVEL (FPL)

Exhibit C FINANCIAL ASSISTANCE APPLICATION (FAP)

EXHIBIT A: Financial Assistance Program Discount Scale

Homeless FPL	0% to 50% FPL	51% to 100% FPL	101% to 150% FPL	151% to 200% FPL	201% to 250% FPL	251% T0 300% FPL	301%-350% FPL	351%-400% FPL
100% of charges	95% of charges	90% of charges	85% of charges	80% of charges	75% of charges	65% of charges	50% of charges	25% of charges

EXHIBIT B: 2021 FEDERAL POVERTY LEVEL (FPL)

Family Size	50%	75%	100%	125%	150%	175%	200%	225%
1	$6,440	$9,660	$12,880	$16,100	$19,320	$22,540	$25,760	$28,980
2	$8,710	$13,065	$17,420	$21,775	$26,130	$30,485	$34,840	$39,195
3	$10,980	$16,470	$21,960	$27,450	$32,940	$38,430	$43,920	$49,410
4	$13,250	$19,875	$26,500	$33,125	$39,750	$46,375	$53,000	$59,625
5	$15,520	$23,280	$31,040	$38,800	$46,560	$54,320	$62,080	$69,840
6	$17,790	$26,685	$35,580	$44,475	$53,370	$62,265	$71,160	$80,055
7	$20,060	$30,090	$40,120	$50,150	$60,180	$70,210	$80,240	$90,270
8	$22,330	$33,495	$44,660	$55,825	$66,990	$78,155	$89,320	$100,485
9	$24,600	$36,900	$49,200	$61,500	$73,800	$86,100	$98,400	$110,700
10	$26,870	$40,305	$53,740	$67,175	$80,610	$94,045	$107,480	$120,915

Family Size	250%	275%	300%	325%	350%	375%	400%
1	$32,200	$35,420	$38,640	$41,860	$45,080	$48,300	$51,520
2	$43,550	$47,905	$52,260	$56,615	$60,970	$65,325	$69,680
3	$54,900	$60,390	$65,880	$71,370	$76,860	$82,350	$87,840
4	$66,250	$72,875	$79,500	$86,125	$92,750	$99,375	$106,000
5	$77,600	$85,360	$93,120	$100,880	$108,640	$116,400	$124,160
6	$88,950	$97,845	$106,740	$115,635	$124,530	$133,425	$142,320
7	$100,300	$110,330	$120,360	$130,390	$140,420	$150,450	$160,480
8	$111,650	$122,815	$133,980	$145,145	$156,310	$167,475	$178,640
9	$123,000	$135,300	$147,600	$159,900	$172,200	$184,500	$196,800
10	$134,350	$147,785	$161,220	$174,655	$188,090	$201,525	$214,960

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EXHIBIT C: FINANCIAL ASSISTANCE APPLICATION

Gunnison Valley Hospital and Family Medicine Clinic (GVH & FMC) is committed to providing emergency and medically necessary care to patients who are uninsured or who have limited insurance (underinsured). You may qualify for financial assistance if you are unable to pay your bill, or if paying it would result in financial hardship.

GVH and FMC provides financial assistance to Gunnison, Hinsdale and Saguache County Residents.

Our Financial Assistance Program provides emergent or medically necessary services at discounted rates for patients who apply for financial assistance and who are qualified.

When applying for Financial Assistance, your cooperation is needed in providing the information and supporting documentation necessary for us to make a fair and timely decision. If complete and accurate information is not provided, your application may be denied, in which case you may be expected to pay your bill in full.

Given the sensitive nature of these requests, all communication with the patient or patient guarantor's will be handled in a confidential and a compassionate manner.

This Financial Assistance Application is being provided to you for completion so that we can determine if you qualify for our Financial Assistance Program.

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COMPLETING THIS FORM IS NOT A GUARANTEE OF ELIGIBILITY

If you do not complete this application packet or if you return it without the requested supporting documentation, we may be unable to determine whether you qualify for our Financial Assistance Program. In that case, you will be responsible for the full balance due on your account.

To determine if you qualify for our Financial Assistance Program, please return the following supporting documentation with this completed packet:

- ✓ A copy of a photo ID (state driver's license/state ID) or other identification documents (Social Security card, alien registry card, birth certificate, baptismal or marriage certificate, passport, visa, employee ID card, etc.).
- ✓ Last year's Form 1040 federal income tax return, with all Forms W-2 and/or 1099.
- ✓ Last two weeks of paystubs with year to date totals, or last three months of paystubs without year to date totals (if paid in cash without paystubs, provide written verification from employer).
- ✓ Proof of income from all other sources such as unemployment compensation, disability income, rental income, pensions, annuities, interest payments, wage and earning statement from Social Security office
- ✓ If you are currently receiving Social Security benefits, a copy of your "benefit amount" letter,
- ✓ Copies of bank statements for checking, savings, certificates of deposit, etc. for the last three months.
- ✓ A copy of a current utility bill, telephone bill, or cable television bill from the residence at which you reside.
- ✓ If you are a student, a list of the current semester's credits/classes and a copy of your student ID.

    - NOTE: The name shown on the patient's photo ID must be the same name shown on paystubs and tax forms.

    - NOTE: Where parents of a minor patient are divorced or separated but share responsibility for the minor's medical care, each parent must complete a separate application.

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FINANCIAL ASSISTANCE APPLICATION

(PLEASE PRINT – BE SURE TO PROVIDE ALL REQUESTED INFORMATION)

I. PERSONAL INFORMATION

Personal information of applicant (or parent, if applicant is a minor):

Name_____ Date of Birth_____
Last First MI

Address_____
Street City State Zip Code

Living at Address Since_____ Phone # (_____)_____ Social Security # _____

Marital Status: Single_____Married_____Divorced _____ Widow _____

Spouse's Name_____Spouse's Social Security # _____Date of Birth_____

List family members (including parents, patient, and natural or adoptive siblings) living at above address.

FAMILY MEMBER'S LEGAL NAME	DATE OF BIRTH	RELATIONSHIP TO PATIENT
1.		
2.		
3.		
4.		
5.		
6.		

II. INSURANCE INFORMATION

	APPLICANT (OR PARENT, IF APPLICANT IS A MINOR)	APPLICANT'S SPOUSE
Do you have health insurance? (Y/N)		
If yes, name of health insurance plan:		
Medicare? (Y/N)		
Medicare Part D? (Y/N)		
Medicare Supplement? (Y/N)		
Medicaid? (Y/N)		
Veteran's Benefits? (Y/N)		

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III. EMPLOYMENT AND INCOME INFORMATION

Employment information of applicant (or parent, if applicant is a minor):

Employer_____Unemployed? (Y/N)____Date of Unemployment_____

Business Address _____

Street City State Zip Code

Phone # (_____) _____Does Employer Offer Health Insurance ? (Y/N) _____

Occupation / Position_____Date of Hire _____

Student (Y/N)_____Name of School_____Number of Credits This Semester_____

MONTHLY SALARY			
GROSS	$	NET	$

HOURLY PAY	$	HOURS WORKED WEEKLY	

Additional Source(s) of Income (per month):

❑ Other wages	$_____	❑ Child Support	$_____	❑ Self Employment	$_____
❑ Interest, Dividends	$_____	❑ Pension/Ret'mt	$_____	❑ SSI/Social Security	$_____
❑ Rental Income	$_____	❑ Worker's Comp	$_____	❑ Veterans Benefits	$_____
❑ Food Stamps	$_____	❑ Unemployment	$_____	❑ Other	$_____
❑ Alimony	$_____	❑ Farm Income	$_____		

Employment information of Spouse (if applicable):

Spouse's Employer _____ Unemployed ? (Y/N)____Date of Unemployment_____

Business Address _____

Street City State Zip Code

Phone # (_____) _____Does Employer Offer Health Insurance ? (Y/N) _____

Occupation / Position_____Date of Hire _____

Student (Y/N)_____Name of School_____ Number of Credits This semester _____

MONTHLY SALARY			
GROSS	$	NET	$

HOURLY PAY	$	HOURS WORKED WEEKLY	

Additional Source(s) of Income (per month):

❑ Other wages	$_____	❑ Child Support	$_____	❑ Self Employment	$_____
❑ Interest, Dividends	$_____	❑ Pension/Ret'mt	$_____	❑ SSI/Social Security	$_____
❑ Rental Income	$_____	❑ Worker's Comp	$_____	❑ Veterans Benefits	$_____
❑ Food Stamps	$_____	❑ Unemployment	$_____	❑ Other	$_____
❑ Alimony	$_____	❑ Farm Income	$_____		

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IV. MONTHLY EXPENSE INFORMATION

Indicate monthly amounts paid or owed on items below:

RENT / MORTGAGE		**HOUSEHOLD BILLS**	
Landlord Name		Heat / Utilities	$
Landlord Phone #	( )	Phone / Cell Phone	$
Mortgage Lender		Cable TV / Internet	$
Mortgage Amount	$	Homeowner's Insurance	$
		Auto Insurance	$
LOANS		Health, Dental, Vision Insurance	$
Auto Loans	$	Life or Disability Insurance	$
Personal Loans	$	Other Insurance	$
Student Loans	$	Medical Bills (hospital / clinic)	$
OTHER OBLIGATIONS		**CREDIT CARDS**	
Child Care	$	Credit Card	$
Child Support	$	Credit Card	$
Alimony	$	Credit Card	$
Other	$		

TOTAL MONTHLY EXPENSES: $_____

V. ASSETS

Indicate current fair market value of any of the following:

BANK ACCOUNTS				**REAL ESTATE OWNED**	
Name of Bank				Value	$
Savings		$		Street Address	
Checking		$		City, State and ZIP	
VEHICLES OWNED				**LIST OTHER ASSETS**	
	Year/Make	Model	Value		$
First			$		$
Second			$		$
Third			$		$

TOTAL ASSETS: $_____

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VII. CERTIFICATION

I certify that the information I have provided in this application and the required supporting documentation is true and correct to the best of my knowledge. I will apply for any federal, state or local assistance for which I may be eligible to help pay for my medical care. I understand that the information provided may be verified by Gunnison Valley Hospital and Family Medicine Clinic, and I authorize Gunnison Valley Hospital and Family Medicine Clinic to contact third parties to verify the accuracy of the information I have provided. I understand that, if I knowingly provide inaccurate or incomplete information in this application, I may be ineligible for financial assistance, any financial assistance granted to me may be reversed, and I will be responsible for the payment of my medical bills.

Applicant's Signature _____Date of Request_____

Your completed application and supporting documentation may be submitted by:

- **EMAIL**: FinancialCounselor@gvh-colorado.org
- **MAIL:** 711 N Taylor St, Gunnison, CO, 81230 | Attn: Financial Counselor
- **IN PERSON:** Gunnison Valley Hospital – South Entrance 711 N Taylor St, Gunnison, CO 82130, Monday through Friday 8:00 am to 4:30 pm
- **QUESTIONS/CONTACT:** (970) 642-4790, Monday through Friday 8:00 am to 4:30 pm

***** To ensure timely processing, please be sure to include all the required information from the checklist on the first page of this application *****