GUNNISON
VALLEY HEALTH

EXHIBIT C

Financial Assistance Application

FINANCIAL ASSISTANCE PROGRAM

Gunnison Valley Health (GVH) 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 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.

GUNNISON
VALLEY HEALTH

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.

If you need help in completing this form or gathering the supporting materials, please contact the Financial Counselor at 970-642-4790

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.

Please return this completed application and the requested supporting documentation as soon as possible. An application will not be reviewed until all required supporting documentation has been provided.

GUNNISON
VALLEY HEALTH

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.		
7.		
8.		

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)		

GUNNISON VALLEY HEALTH

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	$_____		

GUNNISON
VALLEY HEALTH

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: $_____

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 Health, and I authorize Gunnison Valley Health 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 Health – 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 *****

Applicants will be notified within 15 business days after submission of a complete application with all required supporting documentation