Campbell County Health
An Affiliate of UCHealth

Patient Financial Services
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Financial Assistance Application

Applicant Information

Guarantor/Applicant Name _____
Last *First* *M.I.*

Guarantor/Applicant Date of Birth _____ GUAR# _____

Spouse/Co-Applicant _____
Last *First* *M.I.*

Spouse/Co-Applicant Date of Birth _____ GUAR# _____

Address _____
Street Address *Apt/Unit #*

_____
City *State* *ZIP Code*

Phone _____ Email _____

Number in Household _____ Applicant SSN _____ Spouse/Co-Applicant SSN _____

First & Last Names/Ages of Household Members _____

_____

Presumptive eligibility: Do you receive assistance from? (check all that apply, **please provide a copy of the letter received from the agency for proof of participation.**) If none of these apply to your situation please provide the necessary documentation on the next page.

☐ Medicaid/CHIP ☐ SNAP ☐ Homeless Shelter ☐ Section 8 Housing ☐ Other

Disclaimer and Signature

I certify that my answers are true and complete to the best of my knowledge. I will apply for any state, federal, or local assistance for which I may be eligible to help pay for this hospital bill. I understand that the information provided may be verified by the hospital, and I authorize the hospital to contact third parties to verify the accuracy of the information provided in this application. I understand that if I knowingly provide untrue information in this application, I will be ineligible to receive financial assistance.

Guarantor Signature _____ Date _____

Spouse/Partner Signature _____ Date _____

Application Documents

Please provide the following documents (Copies only – originals will not be returned) along with your application to determine eligibility.

- ☐ Two most recent paystubs with gross year-to-date earnings.
- ☐ Most recent and previous years (two years) tax returns.
- ☐ Three months of current Bank Statements for all accounts including checking and savings (with transactions).
  - For applicant and co-applicant
- ☐ SSI/SSDI benefits letter (if applicable).
- ☐ Proof of child support (if applicable).
- ☐ Medicaid denial letter required for all adults and children involved in application.
- ☐ Work Comp/Unemployment benefit letter (if applicable).
- ☐ Letter indicating any additional support or explanation of your financial situation.

If unable to provide the requested information, please write a letter explaining your financial situation.

Financial assistance expires 6 months from the approval date. Adjustments will be made to active and current accounts only.

Financial Information

	Guarantor/Applicant/Frequency	Spouse/Partner or Co-applicant / Frequency
INCOME **Gross Wages / Unemployment / Work Comp**	**$** **/** **Employer:**	**$** **/** **Employer:**
SSI / SSDI Benefits	**$**	**$**
Child Support	**$**	**$**
Retirement / Pension	**$**	**$**
Other Income	**$**	**$**
Bank Name:	**Checking: $** **Savings: $**	**Checking: $** **Savings: $**