Ashley Regional Medical Center
150 West 100 North
Vernal, Utah 84078

DATE RECEIVED_____RECEIVED BY_____

INSTRUCTIONS FOR COMPLETING THIS FORM

In order for a patient to be considered for special financial consideration, this form should be completed and the requested documentation attached, and the form returned by _____(date) .The information will be verified and a proper determination will be made in a timely manner. Please provide the following documentation to the facility. If this information is not received the application will be denied.

1. ___***This form, completed in its entirety.***
2. ___***Complete copies of signed Federal Tax Return with all schedules (For the most recent year).***
3. ___***Copies of payroll check stubs for the previous (3) months.***
4. ___***Copies of 3 current monthly statements and receipts of all listed out- going expenses.***
5. ___***Current bank statement.***
6. ___***Letter explaining your financial hardship. (why you need assistance)***

RESPONSIBLE PARTY INFORMATION

Responsible Party Name: _____ Marital Status: _____

Address: _____ City: _____ St: _____ Zip: _____

Social Security #: _____ Birth Date: _____ Phone #: _____

Employer: _____ Phone #: _____ Date of Hire: _____

Address: _____ City: _____ St: _____ Zip: _____

Spouse's Name: _____ Birth Date: _____ SSN #: _____

Spouse's Employer: _____ Phone #: _____ Date of Hire: _____

Number of Children in the Home: _____ Their Ages: _____

FOR OFFICE USE ONLY

List Account Information for Members in Household:
(For Additional Members - Attach a Separate Sheet if Necessary)

Patient Name:	Account #:	Balance:	Age:	Relationship:

MONTHLY INCOME INFORMATION

Income Sources **(W-2 form, income tax statement, check stubs, or check statements are required for verification. A financial statement may be required if you are self-employed.)**

	Responsible Party	Spouse
	Must have 3 current months of statements for both	
Wages (Before Deductions)	$	$
Alimony / Child Support	$	$
Disability / Worker's Compensation	$	$
Pension	$	$
Social Security Income	$	$
Dividends / Interest / Income	$	$
Rental Income	$	$
Estate / Trust Income	$	$
Welfare / Public Assistance	$	$
Food Stamps	$	$
Other (Please List)	$	$
Less FICA/State/Federal Taxes	$	$
Less Any Other Deductions	$	$
MONTHLY INCOME TOTALS:	$	$

Have you ever filed Bankruptcy? Yes _____ No _____ Year: 19_____

ASSETS	Value		Value
Must have 3 current months of statements			
Cash / Checking	$	Investments	$
Savings	$	Life Insurance	$
Stocks / Bonds	$	Other	$

MONTHLY PAYMENTS

ALL REAL PROPERTY/VEHICLES	Balance Due	Monthly Payment
Must have 3 current months of statements		
Residence (Own ___ Rent ___)		
Other Real Property (List) _____		
Vehicle #1: Make _____ Model: _____ Year: _____		
Vehicle #2: Make _____ Model: _____ Year: _____		
Recreation Vehicle: _____ Model: _____ Year: _____		
Other Vehicle: _____ Model: _____ Year: _____		

MONTHLY PAYMENTS CONTINUED—*Must have 3 current months of statements*

Medical Expenses

Hospital / Physician Name / Pharmacy	Balance Due	Amount Insurance Will Pay	Monthly Payments

List All Other Creditors ***–Must have 3 current months of statements***

(Charge Cards, Mail Order, Gas Cards, etc. - Attach a separate sheet if necessary)

Name of Creditor	Type of Loan	Balance Due	Monthly Payments
Appliance Furniture Rental:			
Other:			

Other Monthly Expenses — ***3 current months of statements*** — Monthly Payment

Food . . . . . _____

Must have 3 currently months of statement for all below

Auto Insurance
6 months $_____ _____
Gasoline . . . . . _____

Health Insurance _____
(If not deducted from payroll) . . . . _____
Prescriptions . . . . . _____

Utilities:
Heating Fuel . . . . . _____
Phone . . . . . _____
Water / Garbage . . . . _____
Electrical . . . . . _____
Cable TV . . . . . _____

Contributions . . . . . _____
Other (List):
_____ _____

PAYMENT SUBTOTALS: $_____

Monthly Financial Summary

TOTAL INCOME: $_____

SUBTOTALS:

Real Property / Vehicles $_____

Monthly Medical Expenses $_____

Revolving Credit $_____

Other Monthly Expenses $_____

TOTAL EXPENSES $_____

- Have you applied for Medicaid and been denied or found to be ineligible? If so, attach denial.
  Yes _____ No _____
- Children present in home? Yes_____ No_____

IF NO IS CHECKED, THE APPLICATION IS DENIED unless no children are present in home.

- Have you asked for assistance from your family? Yes _____ No _____

IF YES, WHAT WAS THE OUTCOME

_____

IF NO IS CHECKED APPLICATION IS DENIED

- Have you asked for assistance from your clergy / church? Yes _____ No _____

IF YES, WHAT WAS THE OUTCOME

_____

IF NO IS CHECKED, THE APPLICATION IS INCOMPLETE. MUST STATE WHY YOU DID NOT ASK FOR ASSISTANCE

- How much are you able to pay each month? $ _____(If there is no amount listed here we will not be able to process this application, no account is written off at 100%. Monthly payments **must** be made during the time this application is being processed)

I hereby state that the information I have provided is true and complete. I authorize Ashley Regional Medical Center to verify this information, including requesting a Credit Bureau Report. I understand that if any of this information is determined to be deceptive or false, I may be denied special financial consideration and I will be liable for any and all charges incurred for services rendered.

[ ] _____ _____
Responsible Party's Signature Date

FOR OFFICE USE ONLY

APPROVAL SIGNATURES AND COMMENTS

_____ _____
Financial Counselor Date

_____ _____
Patient Financial Services Director / Manager Date

FACILITY COMMENTS: _____

_____

_____

Total Charges: $_____ Insurance Payments: _____ Patient Payments:_____

Financial Consideration: _____ Total Balance Due: _____