HOT SPRINGS COUNTY MEMORIAL HOSPITAL **Financial Assistance Policy**

Exhibit A

REQUEST FOR FINANCIAL ASSISTANCE

(ASSISTANCE APPLICATION)

I the undersigned, request the Hot Springs County Memorial Hospital (HSCMH) determine if I am eligible for financial assistance on my unpaid patient account balances. I understand that I must provide all the financial and demographic information requested by HSCMH for my application to be considered. I also understand that Hot Springs County Memorial Hospital will verify the information I provide for accuracy and completeness. I have been informed that it will take HSCMH 30-60 days from the date a complete application and all required documentation is received to make a determination.

I understand that the act of submitting this completed application and supporting documentation does not guarantee that I will be granted financial assistance. If it is determined that based on the HSCMH Income Guidelines I am not granted financial assistance, that I have 30 days to submit a written appeal and attach any additional information previously not provided. Upon receipt of the notification that financial assistance has not been granted or only partial financial assistance has been granted, I agree to be responsible for all unpaid patient accounts connected to me as a guarantor, and I agree to contact the HSCMH customer service (1-855-484-1299) to make payment arrangements.

Please fill out the application and submit online or return the application by mail. Please also return all of the required documentation to:

HOT SPRINGS COUNTY MEMORIAL HOSPITAL
150 East Arapahoe
Thermopolis, WY 82443

NAME_____ Social Security#_____
First Middle Last

Address_____ County _____Date of birth_____
Street City Zip

Phone #_____ Male___ Female___ Marital Status_____Us Citizen - Yes No
(Please circle one)

Employer name _____ Employer Ph#_____

Employer address_____

SPOUSE NAME_____ Social Security #_____

Date of birth____/____/____

Spouse employer_____

Employer address_____ Employer Ph#_____

List of all people living in your home:

Name	Relationship	DOB	Age	Sex	SS#	US citizen?
						Y / N
						Y / N
						Y / N
						Y / N
						Y / N

*If more family Members, Please continue on the back or attach an additional sheet

Is anyone in the home disabled? _____ Do they receive disability income? _____ Please list:

Name	Age	Sex	Income amount?
Name	Age	Sex	Income amount?
Name	Age	Sex	Income amount?

Have you applied for assistance here before?_____ When?_____

Name of Insurance Coverage _____ Primary Physician Name_____

(1) Private Insurance
(2) Medicaid
(3) Medicare
(4) Self-pay
(5) Other

Are you a fulltime student? _____ Do you receive grants or financial assistance? _____ How much?_____
Please provide documentation concerning grants or financial assistance for schooling.

Do you have any workers compensation or liability (MVA, fall or injury) claim not settled? _____
Is there any litigation or settlement case pending? _____
If yes, please supply attorneys name, address and phone:

_____

_____

Gross Income:

	Weekly	Monthly	Annually
Wages (Self)			
(Spouse)			
(Other Family Income)			
Farm or self-employment			
Public Assistance			
Social Security			
Disability Benefits			
Unemployment Compensation			
Alimony			
Child Support			
Military Family Allotments			
Pensions			
Income from Dividends, Interest, ect.			

If none, how are your housing, food and transportation expenses met?

_____

_____

_____

Necessary Monthly Expenses:

Mortgage/Rent _____*
Gas _____
Electric _____
Water & Sewage _____
Home telephone _____
Garbage _____
Food _____
Auto Loan (1) _____
Auto Insurance _____
Daycare _____
Gas to and from work _____
Medical Insurance _____
Medication _____

Other monthly expenses:

Auto Loan (2) _____
Cable _____
Internet _____
Cell phone _____
Other Medical Bills _____
(Please provide copies of other medical bills)
Credit card or other financial companies:
_____
_____
_____
_____
_____
_____
(Please list any additional on the back)

*If no mortgage or rent, source of housing_____ Total Expenses_____

Do you own a home? Yes____No ____
Appraised Value: _____ Date Appraised: _____
Amount Owed: _____

Do you own other land or property? Yes__No ___
Appraised Value: _____ Date Appraised: _____
Amount Owed: _____

Do you own a boat? Yes____No ____
*Please list:_____
Model & Make _____Year _____
Registered Owner: _____
Blue Book Value: _____ Balance Due: _____

Do you own recreational vehicles? Yes___No ____
Model & Make _____Year _____
Mileage: _____ Registered Owner: _____
Blue Book Value: _____ Balance Due: _____

Do you own automobiles? Yes____No ____
Model & Make _____Year _____
Mileage: _____ Registered Owner: _____
Blue Book Value: _____ Balance Due: _____

Model & Make _____Year _____
Mileage: _____ Registered Owner: _____
Blue Book Value: _____ Balance Due: _____

Model & Make _____Year _____

Mileage: _____ Registered Owner: _____

Blue Book Value: _____ Balance Due: _____

Model & Make _____Year _____

Mileage: _____ Registered Owner: _____

Blue Book Value: _____ Balance Due: _____

Bank References: **Type of Account Savings/Checking**

Name/Branch_____Account #_____ _____

Name/Branch_____Account #_____ _____

Name/Branch_____Account #_____ _____

Name/Branch_____Account #_____ _____

Name/Branch_____Account #_____ _____

Name/Branch_____Account #_____ _____

Stocks/Bonds/Etc. _____ Account #_____ _____

401K/Retirement Savings: _____ Account #_____ _____

- I declare under penalty of perjury that the answers I have given are true and correct to the best of my knowledge.
- I understand that my eligibility statements will be subject to verification by contact with my employer, bank, credit verifications and property searches.
- I understand that the County and Hospital are required by law to keep all information I provide confidential.
- I further agree that in consideration for receiving services as a result of an accident or injury, to reimburse the hospital from proceeds of any litigation or settlement.
- I understand that if I do not qualify for uncompensated services, I will be personally liable for the charges of the services rendered by the Hospital or I may appeal decision in writing with additional documentation within 30 days.
- If I have Hot Springs County Memorial Hospital accounts that are placed at a collection agency, it is my responsibility to contact that agency and let them know I am applying for assistance.

Please list any information you feel will be necessary for us to consider when reviewing your application:

_____

_____

_____

Please list two people that are familiar with your situation (name, address, phone) that you give us permission to contact:

_____

_____

_____

_____

_____

_____ _____

Signature Date

_____ _____

Spouse Signature (if applicable) Date