HOT SPRINGS HEALTH

FINANCIAL ASSISTANCE

PATIENT NAME: _____

ACCOUNT NUMBER(S): _____

MEDICAL RECORD #: _____

CURRENT BALANCE: _____

DATE(S) OF SERVICE:_____

Dear Patient:

You have been referred as a candidate for Financial Assistance. In order to complete the application, you will need to provide us with the following information:

1. Completed Financial Assistance Application with signatures.
2. Proof of the gross income for the past 12 months for ALL members of your household receiving income. Proof of income includes ALL of the following:
   a. Copy of previous year's Federal Tax Return: include ALL pages of the tax forms OR proof of non-filing status from the IRS (800-829-1040).
   b. Copy of last three months current pay stubs or the last pay stubs received.
   c. All documentation you have regarding unemployment and/or Workers Compensation benefits, alimony, child support, WIC, Foods Stamps, and/or other financial support. Letter(s) from any person(s) who support or assist you financially. Summary of the Business Income/Expenses if Self-Employed.
3. Copy of last 3 months of ALL checking or savings bank statements.
4. Denial from Medicaid, or other State of WY Assistance programs.
5. If unable to work, a signed letter from your Physician documenting the inability to work.
6. Currently rental agreement if renting.
7. If you own property, please provide a copy of the current County Assessors Assessment of the property and a current copy of the Mortgage Invoice that reflects the current mortgage amount, and
8. Copies of all outstanding medical bills from other Medical Providers.

Please mail all information to:
Hot Springs Health, Attn: Financial Counselor, 150 E. Arapahoe, Thermopolis, WY 82443 within 15 days. Should you have any questions, please refer to the bottom of this letter to contact the appropriate patient accounts representative.

Thank you for your cooperation in this matter.
Sincerely,

Financial Counselor
307-864-3121 ext 5095

HOT SPRINGS HEALTH

REQUEST FOR FINANCIAL ASSISTANCE
(ASSISTANCE APPLICATION)

I the undersigned, request the Hot Springs Health (HSH) 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 HSH for my application to be considered. I also understand that Hot Springs Health will verify the information I provide for accuracy and completeness. I have been informed that it will take HSH 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 HSH 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 HSH customer service (1-855-257-2548) to make payment arrangements.

Please fill out the application and submit online or return the application by mail.
Return all required documentation to:
Hot Springs Health
150 East Arapahoe
Thermopolis, WY 82443

First Name: _____ Middle _____ Last Name _____

Social Security#_____ Date of Birth _____ Marital Status _____

Address_____ City _____ Zip_____

County _____ Phone Number _____

Please circle: Male Female US Citizen: Yes No

Employer name _____ Employer Phone Number:_____

Employer address _____

Spouse Name _____ Social Security # _____

Date of birth: _____

Spouse Employer _____

Employer Address _____ Employer Phone Number _____

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 full-time 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, etc.				

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 _____

WYOMING MEDICAID

What is Medicaid?
Medicaid helps pay for Healthcare service for children, pregnant women, families with children, and individuals who are aged, blind or disabled who qualify based on citizenship, residency, family income, and sometimes resources and healthcare needs.

How do I apply?
You can apply online at www.wesystem.wyo.gov
You can apply over the phone at 855-294-2127
You can complete a paper application and mail to:

Wyoming Department of Health
6101 Yellowstone Road Suite 259D
Cheyenne, WY 82002

Persons interested in other programs offered through the Department of Family Services such as SNAP, POWER, or Child Care, please visit the Department of Family Services website at www.dfsweb.state.wy.us

If you have questions about Supplemental Security Income (SSI) or would like to apply for SSI, visit the Social Security Administration's website at: www.ssa.gov.