

# Financial Assistance Eligibility Application



**Thank you for your interest in becoming a patient at MarillacHealth.** You are encouraged to apply for financial assistance, regardless of your insurance coverage.

The attached forms are part of the application process to determine your eligibility for the Sliding Fee Discount Program or other financial assistance programs that you may qualify for. It is important you read all of the forms and attach the required documents.

1. **ID:** Please bring a form of identification for **ALL** household members that are applying for services. Examples of approved ID: Colorado ID, passport, other state ID, birth certificate, Medicaid or CHP+ card, ID from your country, school ID, permanent resident card.
2. **Earned Income:** Please bring **one of the following** for all employed family members
  - Proof of income for last 30 days (pay stubs)
  - Income verification letter from your employer
  - If no income, talk with our Eligibility Specialist
  - Self-employed: one month of gross bank business deposits or current month of Profit & Loss Statement or current tax return
3. **Unearned Income:** Please provide copies of these unearned income if applies to you:
  - Unemployment
  - SSI
  - Pensions / Retirements
  - Worker's Compensation
  - Disability Benefits
  - Rents, Alimony
4. **Medical and/or Dental Insurance Cards:** Please provide copies of front and back of cards

If you have any questions regarding the application or documents requested or to speak to our Eligibility Specialist, please call our Eligibility Office at **970.200.1654**. Once your application is processed, we will contact you to let you know if you qualify for the Sliding Fee Discount Program. You can then come in to sign and pick up your card. Thank you again for contacting MarillacHealth. We look forward to serving you and all of your health care needs.

***MarillacHealth accepts Medicaid, Medicare, Rocky Mountain Health Plans, Other Commercial Plans, Delta Dental, and Self Pay/Uninsured. A Sliding Scale Discount Program is available to everyone. Eligibility is based on family size and income.***

**Mail or drop off Eligibility Forms to either of our locations in Grand Junction:  
2333 N. 6<sup>th</sup> Street, Grand Junction, CO 81501  
or 510 29 ½ Road, Grand Junction, CO 81504  
Eligibility Office: 602 Bookcliff Avenue, Grand Junction, CO 81501**

2333 N 6<sup>th</sup> St. Grand Junction, CO 81501  
510 29 ½ Rd, Grand Junction, CO 81504  
[www.MarillacHealth.org](http://www.MarillacHealth.org)

Medical & Dental: 970.200.1600



# Financial Assistance Eligibility Application



Date: \_\_\_\_\_

Services you are applying for:  
 Medical  Dental  Optical

## Patient Information

First Name (Legal): \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN#: \_\_\_\_\_ Gender:  Male  Female  Transgender  
 Other not listed \_\_\_\_\_

Household Status:  Not Homeless  Homeless (circle): Street Doubling Up Transitional Homeless Shelter Other

Public Housing:  No  Yes(circle): Lincoln- Bunting Lincoln- North Courtyard Bookcliff

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Physical Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Mobile/Cell Phone: \_\_\_\_\_

Marital Status:  Married  Single  Common Law  Divorced  Widow Email: \_\_\_\_\_

Employment Status:

Disabled  Full Time  Part Time  Retired  Student  Not Employed  Other

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Ethnicity:  Hispanic  Non-Hispanic Preferred Language: \_\_\_\_\_

Race:  American Indian  Asian  Native Hawaiian  Black/African American  White

Pacific Islander  Other: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ Emergency Contact Phone: \_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_ Current Primary Care Provider: \_\_\_\_\_  None

## Guarantor Information (Person Responsible for Payment of Accounts/Services)

First Name (Legal): \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN#: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Mobile/Cell Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

## Insurance

Type of Insurance / Sliding Scale:

Medicaid  Medicare  CHP+  CICIP  Private  Sliding Scale  None

**PRIMARY INSURANCE:** \_\_\_\_\_ **GROUP NUMBER:** \_\_\_\_\_

Address: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Subscriber/Insured Name: \_\_\_\_\_ Subscriber Date of Birth: \_\_\_\_\_ Subscriber SSN#: \_\_\_\_\_

Relation to Patient: \_\_\_\_\_ Subscriber Employer: \_\_\_\_\_



# Financial Statement

**INCOME:** List ALL household income by **GROSS MONTHLY** amount:

Source of Income	Yours	Spouse	Dependent(s)
Monthly Gross Wages	\$	\$	\$
Unemployment Compensation	\$	\$	\$
AFDC*	\$	\$	\$
Child Support	\$	\$	\$
Retirement /Pension	\$	\$	\$
Social Security	\$	\$	\$
Rental/Interest Income	\$	\$	\$
Other	\$	\$	\$
<b>TOTAL INCOME:</b> *Not included in Total	\$	\$	\$

**I CERTIFY THAT THE INFORMATION PROVIDED IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL REPORT ANY CHANGES IN MY SITUATION WITHIN ONE MONTH.**

Signature \_\_\_\_\_ Date \_\_\_\_\_





**AFFIDAVIT FOR LAWFUL PRESENCE  
COLORADO INDIGENT CARE PROGRAM**

I, \_\_\_\_\_, swear of affirm under penalty of perjury under the laws of the State of Colorado that **(check one)**:

- I am a United States citizen.
- I am not a United States citizen but I am a Permanent Resident of the United States.
- I am not a United States citizen but I am lawfully present in the United States pursuant to Federal law.

I understand that this sworn statement is required by law because I have applied for a “state public benefit”, as that term is defined under section 24-76.5-102(3), C.R.S. (2016). I understand that state law requires me to provide proof that I am lawfully present in the United States prior to receipt of this state public benefit. I further acknowledge that making a false, fictitious, or fraudulent statement or representation in this sworn affidavit is punishable under the criminal laws of Colorado as perjury in the second degree under section 18-8-503 C.R.S. (2016), and it shall constitute a separate criminal offense each time a public benefit is fraudulently received.

Signature:

Date:

**FOR INTERNAL USE ONLY**

**Please mark the box that indicates which document was verified for lawful presence and keep a photocopy of the document present in the applicant’s file.**

- A current, valid Colorado driver’s license or a Colorado identification card, issued pursuant to article 2 of title 42, C.R.S., unless that license or card states: “Not Valid for Federal Identification, Voting, or Public Benefit Purposes”, or
- Any out-of-state driver’s license or state-issued identification card if that state requires that the Applicant prove lawful presence prior to issuance of the license or identification card, or
- A United States military or a military dependent’s identification card, or
- A United States Coast Guard Merchant Mariner card, or
- A Native American tribal document, or

Other documentation pulled from SAVE or found on a Federal list of acceptable documentation for establishing lawful presence (see 1 CCR 204-30 §§ 2.1.4 and 2.1.6)

Name of document accepted (include document number): \_\_\_\_\_

Date verified in SAVE (if applicable): \_\_\_\_\_



**SELF AND THIRD-PARTY DECLARATION**

**Please Note:** If the applicant is a United States citizen and is unable to present any of the documents listed on this form they may submit a written declaration or a third-party written declaration. These options should be used with caution and only as a last resort. The applicant must sign below.

I, \_\_\_\_\_, self-declare and swear or affirm under penalty of perjury, and possibly subject to later verification of status, that I am a United States citizen or non-citizen national.

Signature

Date:

I, \_\_\_\_\_, swear or affirm under penalty of perjury, and possibly subject to later verification of status, that I have personal knowledge that the Applicant is a United States citizen or non-citizen national.

Signature

Date:

For Colorado Department of Revenue's Lawful Presence Rule, see 1 CCR 204-30 Rule 5:  
<http://www.sos.state.co.us/CCR/GenerateRulePdf.do?ruleVersionId=6860&fileName=1%20CCR%20204-30>

States that require Applicants to prove lawful presence prior to issuing a driver's license or identification card are also called REAL ID compliant states. A list of REAL ID compliant states can be found here: <https://www.dhs.gov/current-status-states-territories>