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. <u>ID</u>: Please bring a form of identification for <u>ALL</u> 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. <u>Unearned Income</u>: 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. 6th 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 6th St. Grand Junction, CO 81501 510 29 ½ Rd, Grand Junction, CO 81504 www.MarillacHealth.org

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Financial Assistance Eligibility Application



| Date: | | Services you are applying for: ☐ Medical ☐ Dental ☐ Optical |
|---|---|--|
| | Patient Information | |
| First Name (Legal): | Middle Initial: Last Nan | ne: |
| Date of Birth: | | nder: Male Female Transgender |
| | | ☐ Other not listed |
| Household Status: ☐ Not Homeless ☐ Hom | neless (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 | n 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 ☐ Asia | n □ Native Hawaiian □ Bla | ack/African American |
| ☐ Pacific Islander ☐ Other: | | _ |
| Emergency Contact: | Relationship to Patient: | Emergency Contact Phone: |
| Preferred Pharmacy: | Current Primary Care I | Provider: None |
| Guarantor Inform | ation (Person Responsible for Payment o | f Accounts/Services) |
| First Name (Legal): | Middle Initial: Last N | lame: |
| Date of Birth: | SSN#: | Relationship to Patient: |
| Mailing Address: | City: | State:Zip: |
| Home Phone: | Mobile/Cell Phor | ne: |
| Employer: | Work Phone: | |
| | Insurance | |
| Type of Insurance / Sliding Scale: | | |
| ☐ Medicaid ☐ Medicare ☐ CHP | P+ □CICP □Private □ S | liding Scale □ None |
| PRIMARY INSURANCE: | GROUP NUI | MBER: |
| Address: | | r: |
| | | Subscriber SSN#: |
| Relation to Patient: | | nployer: |
| | | |

Financial Assistance Eligibility Application



| Household Members | | | | | | | | | |
|---|--|---|---|------------------|-------------------|---|---------------------|--------------------|---------------------------|
| | Resident Code | Family Member's Name | Social Security # | Date of Birth | Male or Female | Relationship | Medicaid # or CHP # | Medicare Yes/No | Name of Private Insurance |
| 1. | 0040 | | | | - Cinare | | 0.0111 | 100,110 | Trivate insulance |
| 2. | | | | | | | 1 | | |
| 3. | | | | | | | | | |
| 4. | | | | | | | | | |
| 5. | | | | | | | | | |
| 6. | | | | | | | | | |
| 7. | | | | | | | | | |
| 8. | | G 1 7 11 | | | | | | | |
| ((| 1) Colorad | Code Table: lo Resident & U.S. Citizen t farm worker & documented immigrant | (02) Colorado Resident & (05) Non-Resident, Count | | - | (03) Migrant farm v (06) Medicaid eligil | | | |
| | | | | Other Info | rmatio | ı | | | |
| Been hired to do agricultural work? ☐ Yes ☐ No Earned the majority of your income or employment from agricultural work? ☐ Yes ☐ No Moved temporarily in order to do agricultural work? ☐ Yes ☐ No Stopped working in agriculture because of disability or old age? ☐ Yes ☐ No US Veteran Status: Have you (patient) completed service in the Uniformed Services of the United States? ☐ Yes ☐ No I certify that the above information is true, accurate, and complete to the best of my knowledge. I permit MarillacHealth representatives to contact any necessary person or agency to verify this information. I agree to notify MarillacHealth promptly of any changes in household members, address, phone, income, insurance or other essential information. I understand I must show my card at time of service based upon the guidelines established by MarillacHealth and/or the State of Colorado. I understand I amresponsible for any charges for services and I agree to pay my fee/copay at time of service. The undersigned hereby consents to MarillacHealth's use of patient's medical information for those health care operations as defined in the HIPAA privacy regulations (45CFR164.501) not otherwise permitted under Colorado Law, which shall include uses such as medical review, legal services, auditing functions, business planning development, business management and general administrative activities. MarillacHealth is further authorized to disclose patient's medical information to its business associates, such as accountants, attorneys, consultants, and others who perform some of the foregoing health care operations on MarillacHealth's behalf. | | | | | | | | | |
| C: ~ | antuma -f | Client/Parent/Guardian/Patient Represo | ontativo | Date | | - | FFE CODE | | FPI % |
| Signature of Client/Parent/Guardian/Patient Representative Date FEE CODEFPL% | | | | | | | | | |
| Print Name | | | | | | | | | |
| If oi | f signed by other than client, indicate relationship | | | | | | | | |
| . 1 31 | | | | | | | | | |

Note: Client representatives shall be required to provide documentation of explanation of authority to act for the client. We will not process any requests signed by a client's representative if authority to act for the client is not clearly described.

2333 N 6^{th} St. Grand Junction, CO 81501 510 29 ½ Rd, Grand Junction, CO 81504 www.MarillacHealth.org

Rev. May 2021

Medical & Dental: 970.200.1600

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 | \$ | \$ | \$ |
| *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, | | | |
|---|--|--|--|
| ☐ 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): | | | |

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, penalty of perjury, and possibly subject to la citizen or non-citizen national. | , self-declare and swear or affirm under atter verification of status, that I am a United States |
|--|--|
| Signature | Date: |
| | |
| 3 | , swear or affirm under penalty of ation of status, that I have personal knowledge that on-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