Financial Assistance Eligibility Application

MarillacHealth
Committed to a healthier you.

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. 6th Street, Grand Junction, CO 81501
or 510 29 ½ Road, Grand Junction, CO 81504
Eligibility Office: 602 Bookcliff Avenue, Grand Junction, CO 81501

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Date:

Services you are applying for:
Medical Dental

Patient Information

First Name (Legal):_____ Middle Initial:____ Last Name:_____

Date of Birth: SSN#: Gender: Male Female Transgender

Other not listed_____

Household Status:

Public Housing:

Mailing Address:_____ City: _____State: _____Zip:_____

Physical Address:_____City: _____State: _____Zip:_____

Home Phone:_____ Mobile/Cell Phone: _____

Marital Status: Email: _____

Employment Status:

Employer:_____ Work Phone:_____

Ethnicity: Preferred Language: _____

Race:

Emergency Contact:_____ Relationship to Patient:_____ Emergency Contact Phone:_____

Preferred Pharmacy: _____ Current Primary Care Provider: _____

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:

PRIMARY INSURANCE:_____ **GROUP NUMBER:**_____

Address:_____ Policy Number:_____

Subscriber/Insured Name:_____ Subscriber Date of Birth:_____ Subscriber SSN#:_____

Relation to Patient:_____ Subscriber Employer:_____

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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.									
2.									
3.									
4.									
5.									
6.									
7.									
8.									

Residency Code Table:
(01) Colorado Resident & U.S. Citizen
(02) Colorado Resident & documented immigrant
(03) Migrant farm worker & U.S.Citizen
(04) Migrant farm worker & documented immigrant
(05) Non-Resident, Counted in family size only
(06) Medicaid eligible, counted in family size only

Other Information

Over the past 24 months, have you (patient) or a member of your family:

- 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 am responsible 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.

_____
Signature of Client/Parent/Guardian/Patient Representative

_____
Print Name

_____
If signed by other than client, indicate relationship

FOR STAFF USE ONLY
FEE CODE_____ FPL%_____
ELIGIBILITY SPECIALIST SIGNATURE:
_____
DATE _____/_____/_____

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.

Financial Statement

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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	$	$	$
TOTAL INCOME: *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 _____