MarillacHealth
Committed to a healthier you.

Financial Assistance Eligibility Application

Thank you *for your interest in becoming a patient at The PIC Place / 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, ID from your country, school ID, permanent resident card.
2. **Earned Income:** Please bring any one of the following for all employed family members:
    - Proof of income for last 30 days (pay stubs)
    - Income verification from your employer
    - If no income, talk with our Eligibility Specialist
    - Self-employed: Profit & Loss Statement
3. **Unearned Income:** Please provide copies of these unearned income if this applies to you:
    - Unemployment
    - Worker's Compensation
    - SSI
    - Disability Benefits
    - Pensions/Retirement
    - 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 **The PIC Place at 970-252-8896** or the MarillacHealth Eligibility Office at 970-200-1654 or 970-200-1647. Once your application is processed, we will contact you to let you know if you qualify for the Sliding Fee Discount Program. We will mail your card to you. Thank you again for contacting MarillacHealth. We look forward to serving you and all of your health care needs.

MarillacHealth accepts Medicaid, Medicare, Medicare Advantage, Rocky Mountain Health Plans, other commercial plans, Delta Dental, and self-pay/uninsured. Eligibility is based on family size and income.

Mail or drop off Eligibility Forms to any of our locations:

87 Merchant Drive, Montrose, CO 81401
2333 N. 6th Street, Grand Junction, CO 81501; 2139 N. 12th Street, Ste. 2, Grand Junction, CO 81501
510 29 ½ Road, Grand Junction, CO 81504; Eligibility Office: 602 Bookcliff Avenue, Grand Junction, CO 81501

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Today's Date:	Current Primary Doctor:

PATIENT INFORMATION

Last Name:	First Name (Legal)	Middle Initial:

Mailing Address:	City:	State	ZIP:

Date of Birth:	Social Security Number	Marital Status
		Single Married Divorced Widowed Civil Union

Gender Identity (Circle):	Sexual Orientation (Circle):
Masculine Feminine Transgender Man Transgender Woman Choose not to disclose	Heterosexual Lesbian/Gay Bisexual Other

Home Phone:	Cell Phone:	Employment Status:

Employer:	Work Phone:

Race (Circle):	Primary Language:	
Alaska Native American Indian Asian Black/African-American Hawaiian Native Pacific Islander Patient Refused Unknown White Other _____	Ethnicity (Circle):	Hispanic Not Hispanic Prefer Not to Answer

Housing Status: (Circle):	Public Housing (Circle):	Location (Circle):	
Not Homeless Homeless	No Yes	Lincoln—Bunting Bookcliff	Lincoln—North Courtyard Other: _____

Name in case of emergency:	Relationship:	Phone in case of emergency:

Preferred Pharmacy:

Email Address:

Other notes:

87 Merchant Dr., Montrose, CO 81401
2333 N. 6th St. Grand Junction, CO 81501
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510 29 ½ Rd. Grand Junction, CO 81504

Phone: 970-252-8896
Phone: 970-200-1600
Fax: 970-200-1611
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Revised Sept. 2023

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Person Responsible for Payment		
Last Name:	First Name:	Middle Initial:
DOB:	Social Security Number:	Relationship to Patient:
Mailing Address:		
Home Phone:	Cell Phone:	
Employer:	Work Phone:	
Insurance		
Type of Insurance/Sliding Scale:		
Primary Insurance:	Group Number:	
Address:	Policy Number:	
Subscriber/Insured Name:	Subscriber DOB:	Subscriber Social Security Number:
Relationship to Patient:	Subscriber Employer:	

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Miembros del Hogar									
Resident Code		**Family Member's Name**	**Social Security #**	**DOB**	**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 and US CItizen
(02) Colorado Resident & Documented Immigrant
(04) Migrant Farm Worker & Documented Immigrant
(05) Non-Resident, Counted in Family Size Only

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 State? 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 on the guidelines established by MarillacHealth and/or the State of Colorado. I understand I am responsible for any charges, and I agree to pay my fee/copay at time of service.

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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 (45CFR 164.501) 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/Patient/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.

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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	$	$	$
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: _____

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