Clark Fork Valley Hospital
& Family Medicine Network

HEALTHCARE FINANCIAL ASSISTANCE APPLICATION

General Information

GUAR #

Date Received (Office Use Only)

Patient Name _____

Last 4 digits of Social Security _____ Date of Birth _____

Please Circle One: Single Married/Significant Other Divorced/Separated Widow/Widower

Spouse/ Guardian _____ Guar # _____

_____

Last 4 digits of Social Security _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____ County _____

Patient Home Ph # _____ Cell Ph # _____ Work Ph # _____

Spouse/Guardian Home Ph # _____ Cell Ph # _____ Work Ph # _____

Email _____

Name(s) and age(s) of dependents living with you for whom you are responsible. Please include DOB:

_____

_____

Monthly Income	**Yours**		**Spouse**	
Gross Pay				
Alimony/Child Support				
Social Security				
Unemployment/Work Comp				
Retirement/Pension				
Interest/Rental				
Other				
Monthly Total				

Additional information if needed:

_____

_____

_____

_____

_____

GUAR #

Current Employer _____

Address _____

Phone # _____ Occupation _____

Length of Employment _____ Years _____ Months Full Time / Part Time

Number of hours scheduled to work each week _____

If unemployed, date of unemployment _____ Are you receiving unemployment? Yes / No

If Yes – Beginning Date _____ Amount receiving weekly _____

Spouse/Significant Other's Employer _____

Address _____

Phone # _____ Occupation _____

Length of Employment _____ Years _____ Months Full Time / Part Time

Number of hours scheduled to work each week _____

If unemployed, date of unemployment _____ Are you receiving unemployment? Yes / No

If Yes – Beginning Date _____ Amount receiving weekly _____

Other Assistance

Do you receive food stamps? _____ Yes _____ No

Do you have medical benefits? _____ Yes _____ No

If no, have you applied for Medicaid? _____ Yes _____ No Date Applied _____

If benefits were denied, what reason was given? _____

Date Medicaid was denied _____

Your signature is required below:

My signature attests that the information I provided within this form is accurate and true to the best of my knowledge. I understand that CFVH requires verification of income before any determination can be made.

I also understand that my credit may be accessed, at no expense to me, to verify the above information.

Signature _____ Date _____

Required Documentation: Only provide applicable Income Documentation.

- Completed, signed and dated Healthcare Financial Assistance Application
- 3 months of pay stubs for you, spouse and/or significant other *(Copies)*
- 3 months of bank statements *(Copies)*
- Award letter(s) for unemployment, social security, pension, etc. *(Copies)* – Must display monthly benefit
- Child Support/Court Ordered Maintenance
- Prior year's tax return Form 1040*(Copy)* – Cannot accept W2 Forms
- If unemployed and/or living with friend or family, please explain on Page 1 – space provided or attach a page.
- If self-employed, please provide business ledger for last 3 months *(Copies)*

Please note: **We will deny applications that are incomplete** and do not include the above listed required documentation.

Office Use Only : PT Name **GUAR #**

Family Size _____ Income _____ Yearly Expenses _____ Poverty Level _____

Notes: _____

CONTRACT REVIEW:

Previous Yearly Income _____ Current Yearly Income _____

If different why?

Account Balance: $ _____ New Added Debt: $_____

Date of Last Contract:_____ Previous Financial Stmt attached. Yes No

Previous Monthly PYMT $ Previous payments current: Yes No

Financial Coordinator Name _____ Approved / Denied DATE_____

New Contract Set up

Review Reminder Set