Financial Assistance Application

We are here to help you!

You may qualify for partial or full financial assistance.

Complete the attached documents to see if we can help.

RETURN COMPLETED APPLICATIONS TO:

CRH Patient Financial Services
Attn: Financial Counselors
707 Sheridan Ave
Cody, WY 82414

If you need assistance or have questions, feel free to stop by or call

307-578-2549

Check List

An incomplete application will result in a denial.

Financial Assistance: Date of application must be within six (6) months of date of service.

Application must include all applicable copies of:

- _ The entire previous year's income tax return for everyone in the household.
- _ Copies of all W-2's that go with the previous year's taxes for everyone in the household.
- _ If you did not file a tax return, you will need to call 1-800-829-1040 or go to your local tax office and obtain the form 4506-T. Please fill out the form completely. You will need to make the area on the form that states: 7—Verification of Non-filing. You will receive a letter in approximately 45 days. I will need a copy of the letter once you received it.
- _ We will need two months paystubs for everyone in the household.
- _ All pages of the last 3 months bank statements including savings accounts.
- _ If you are unemployed, I will need a copy of your Unemployment Benefits.
- _ A copy of the letter stating you receive Food Stamps.
- _ A copy or your yearly Social Security Statement.
- _ A copy of your Workman's Compensation and/or Disability Benefits.
- _ A copy of Legal Documents for Child Support and/or Alimony
- _ A copy of Grant or Scholarship statement if attending college.
- _ If you have limited or no income, we will need a Letter of Support from person's helping you.
- _ Please see attached Medicaid questionnaire. You will need to apply for Medicaid and bring in a denial/approval letter from Medicaid. You can apply by calling 855-294-2127.
- _ If you do not have insurance, you will also need to go on the Healthcare Market Place from November 1 to December 31st and apply for health care, if denied you need to bring proof of denial, if accepted, you must purchase it. If you fail to purchase insurance or get your own insurance, the financial aid will be reapplied to your account and you will be responsible for the entire bill.

Financial Aid Application

Name ______________________________________ Age ____ Size of Household _____________
Spouse _____________________________________ Age ____ Phone Number _______________
Address ____
Length ________ Rent __________ Own ________
Previous Address ____ Length _________

Employment Information

Applicant | *Spouse*

Employer ___________________________________ Employer _____________________________
Address ____________________________________ Address _______________________________
Length ________ Monthly Income _____________ Length ______Monthly Income __________
Previous Employer ___________________________ Previous Employer ____________________
Other Income ________________________________ Other Income _________________________

Assets

Bank ______________________________ Checking and/or Saving Account _________________
Vehicles: Make ______________ Year _______ Model ___________ Lien Holder ____________
Vehicles: Make ______________ Year _______ Model ___________ Lien Holder ____________
Home & Other Real Estate Type _______________ Home Valued __________ Owed_________

Debts Owed	Address	Payments	Balance

A. Monthly Expenses

Total of monthly payments from **"Debts Owed"** above	$ __________
Rent or mortgage payment	$ __________
Food	$ __________
Utilities (Heat, Electric, Water, Etc)	$ __________
Transportation (Gas, Oil, Bus Fair, Etc)	$ __________
Insurance (Health, Car, Life, Land, Etc)	$ __________
School Expenses	$ __________
Alimony or Child Support	$ __________
Other	$ __________

B. Monthly Income

Applicant	$ __________
Spouse	$ __________
Other Income ____________________________	$ __________
Total Income	**$ __________**

C. Subtract Expenses from Income $ __________

Net Income **$ __________**

I (we) certify the above to be true and a complete list of all assets & debts. I (we) give permission to Cody Regional Health to verify the information listed above.

Signed __________________________ Date _____________ Social Security # _______________
Signed __________________________ Date _____________ Social Security # _______________

Medicaid Check List

Is there anyone ages 0 to 18 living in the home? YES or NO
Is there pregnant woman in the home? YES or NO
Is there anyone on SSI? YES or NO

If you say yes to any of these questions, please look at the chart below and if your income is **LESS** than the following chart, you will need to apply for Wyoming Medicaid.

If your income is **MORE** than the following chart, please sign below and turn in with your Financial Assistance Application.

Family Size	Family Care and Lower Income Pregnant Women	Children Age 6-18 133 % FPL	Pregnant Woman and Children Age 0-5 154% FPL	Pregnant by Choice 159 % FPL
1	$529	$1305	$1511	$1560
2	$737	$1766	$2045	$2111
3	$873	$2227	$2579	$2662
4	$999	$2688	$3113	$3214
5	$1192	$3149	$3646	$3765
6	$1327	$3610	$4180	$4316
7	$1515	$4071	$4714	$4867
8	$1644	$4532	$5248	$5418
9	$1843	$4994	$5782	$5970
10	$1972	$5455	$6316	$6521

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Signature