



**Financial Assistance Application**

Patient's Information:

Last Name	First Name	Middle Initial	Social Sec. #	Date of Birth
Street Address		City	State	Zip
Mailing Address		City	State	Zip
Home Phone Number		Work Phone Number		Marital Status

Guarantor's Information:

Last Name	First Name	Middle Initial	Social Sec. #	Date of Birth
Address if different from patient		Home Phone Number	Work Phone Number	

**\*\*\*Please indicate ALL people living in the household, including applicant: use additional sheet of paper if needed**

Name	Relationship to patient	Age
	<b>SELF</b>	

Has patient applied for Medicaid Services Yes  No   
 When? \_\_\_\_\_ What is the status? Pending  Denied   
 Reason: \_\_\_\_\_  
 Is there any third party coverage for this account?  
 Medicare  Medicaid  Insurance  Other  Specify: \_\_\_\_\_  
 Is patient disabled?: Yes  No  Temporary  Permanent   
 If disabled have you applied for Social Security? Yes  No   
 If no, why not?: \_\_\_\_\_ If yes, when: \_\_\_\_\_  
 Does patient or guarantor have the ability to work? Yes  No   
 Has patient received uncompensated care before? Yes  No   
 Has patient/guarantor ever filed bankruptcy or do they intend to file? Yes  No   
 If yes, where \_\_\_\_\_ When \_\_\_\_\_ Chapter 7  Chapter 13

**HOUSEHOLD ASSET INFORMATION**

Home/Property Location	_____	
Home/Property Location	_____	
Value of Automobile	\$ _____	\$ _____
Year, Make, Model	_____	_____
Value of Recreational Vehicle	\$ _____	\$ _____
Year, Make, Model	_____	_____
Life Insurance Cash Value	\$ _____	\$ _____

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**HOUSEHOLD INCOME INFORMATION**

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	PERSON 1	PERSON 2	PERSON 3
NAME of each household member	_____	_____	_____
Name of Employer	_____	_____	_____
Monthly Income			
Employment	\$ _____	\$ _____	\$ _____
Self-Employment	\$ _____	\$ _____	\$ _____
Investment Accounts	\$ _____	\$ _____	\$ _____
Real Estate Rentals	\$ _____	\$ _____	\$ _____
Unemployment	\$ _____	\$ _____	\$ _____
Retirement (Social Security, Pension)	\$ _____	\$ _____	\$ _____
Alimony/Child Support	\$ _____	\$ _____	\$ _____
Public Assistance (Food Stamps, etc.)	\$ _____	\$ _____	\$ _____
Other Income	\$ _____	\$ _____	\$ _____
Savings & Investments			
Checking Account Balance	\$ _____	\$ _____	\$ _____
Savings Account Balance	\$ _____	\$ _____	\$ _____
IRA's, Mutal Funds, etc.	\$ _____	\$ _____	\$ _____
Other Savings/Investments	\$ _____	\$ _____	\$ _____

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**HOUSEHOLD EXPENSES**

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Rent: \$ \_\_\_\_\_ or Mortgage Payment: \$ \_\_\_\_\_ Mortgage Balance: \$ \_\_\_\_\_

Do you own property other than you primary residence? Yes  No

Monthly Utilities: \$ \_\_\_\_\_ Insurance: \$ \_\_\_\_\_

Alimony/Child Support: \$ \_\_\_\_\_ Health Insurance: \$ \_\_\_\_\_

Child Care: \$ \_\_\_\_\_ Healthcare bills: \$ \_\_\_\_\_

Medications: \$ \_\_\_\_\_ Auto Loan payments: \$ \_\_\_\_\_

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**ASSIGNMENT OF RIGHTS**

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By signing below I understand that Cheyenne Regional Medical Center reserves the right to verify any and all information submitted on this application. Any information found to be incorrect without good reason shall render the application incomplete and ineligible for community care. I further understand that Cheyenne Regional Medical Center, at its discretion, may obtain a copy of my credit report.

All information provided will remain confidential under the provisions of HIPPA federal regulations I agree that I will repay the full financial assistance award if I receive payment of any kind for the medical services covered by this application, for example insurance payments, government program payments, awards from a lawsuit or any other payment.

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
County of Residency

\_\_\_\_\_  
State of Residency