Central Valley Medical Center

48 W 1500 N • PO Box 412 • Nephi, UT 84648 • Phone 435-623-3000

Financial Assistance Application

If you need help completing this form please contact Halle Peterson at 435-623-3195 or email hpeterson@cvmed.net.

Instructions for completing this form:

Please fill this form out completely and return all required documentation to Central Valley Medical Center. Patients may not receive financial assistance if they do not complete the application process.

We require that you apply for Medicaid through the Utah Department of Health, even if you have other insurance coverage.

Please attach copies of the following documentation:

1. **Medicaid response letter from the Utah Department of Health.**
2. **Household income verification (paycheck stub(s), unemployment or disability income verification, pension, retirement, W-2 or Federal Tax Return, etc.)**

Patient Name _____ Birth Date _____ Social Security No. _____

Guarantor Name _____ Birth Date _____ Social Security No. _____

Relationship to Patient _____

Mailing Address _____City _____State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Spouse Name _____ Birth Date _____ Social Security No. _____

Home Phone _____ Cell Phone _____ Work Phone _____

Additional Household Members

Name	Birth Date	Relationship to Guarantor

Household Monthly Income

Type	Amount
Employment Income (Gross)	$
Employment Income for Spouse (Gross)	$
Pension/Retirement, Unemployment, Disability Income, etc.	$
Child Support	$
Grants/Scholarships	$
Alimony	$
Other (Please list source):	$

Assets

Type	Financial Institution(s)	Account Balance
Cash		$
Savings Account(s)		$
Checking Account(s)		$
Stocks or Bonds		$

Please turn to the back of this form to complete the application.

Total Monthly Household Expenses

Type	Balance	Monthly Payment
Mortgage/Rent		
Second Mortgage		
Food		
Gas/Heat		
Electric		
Water		
Telephone		
Child Support		
Auto 1		
Auto 2		
Life Insurance		
Bank Loan		
Bank Loan		
Credit Cards		
Credit Cards		
Other Debts		
Total Medical Expenses		

TOTAL MONTHLY EXPENSES $_____

We ask patients who apply for financial assistance to look for other funding also. Please check 'Yes' or 'No'.

Have you applied for any state assistance programs (Medicaid, CHIP, PCN, Crime Victims, etc.)? Yes ☐ No ☐
If yes, list program name: _____

Were you denied Medicaid eligibility or required to pay a spend-down? Please attach a copy of the Medicaid response letter. Yes ☐ No ☐

Do you live with anyone who assumes financial responsibility for rent, utilities, or any other bills or payments belonging to you? Yes ☐ No ☐
If yes, please list bills: _____

Does your employer or spouse's employer offer group health insurance? Yes ☐ No ☐
If yes, list insurance company: _____

Do you have other types of insurance such as Allstate, AFLAC, etc.? Yes ☐ No ☐
If yes, list insurance company: _____

Are you eligible for COBRA through a previous employer? Yes ☐ No ☐
If yes, list COBRA information: _____

Do you have a Health Savings/Flex Savings Account? Yes ☐ No ☐

Does your employer reimburse you for any medical expenses? Yes ☐ No ☐

Do you have family or church assistance? Yes ☐ No ☐

Additional information we should be informed of in order to understand your inability to pay the medical balance. You may attach a separate sheet if more space is needed. Additional documentation may be required.

_____

_____

_____

_____

I hereby state that the information given herein is true and correct. I understand that if this information is determined to be false or deceptive, I will be liable for payment of charges for all services rendered. I understand that this request for financial assistance may not pertain to other health care providers.

Guarantor Signature _____ Date _____

Spouse Signature _____ Date _____

Checklist of all required information to complete application process: _____ Front and back of form filled out completely
_____Household incomes verification (paycheck stub(s) Unemployment, W-2's, etc.) _____ Medicaid response letter

Revised: December 2019