TETON VALLEY HEALTH CARE
Your Healthcare Elevated
120 East Howard Avenue, Driggs, Idaho 83422
208-354-2383 www.tvhcare.org

Financial Assistance Application

Additional documentation is needed to support information given in your Financial Assistance Application. Please include the following:

1. **Last two years tax returns**
2. **Last two months Bank statement (Checking and Savings)**
3. **Two most recent paystubs**
4. **Copy of all current monthly bills**
5. **Any other documents to support your financial situation**

If this initial information is not returned with the application, your application will be automatically denied.

Financial Statement Application Form

Patient:		Account #:
Account #	Account #:	Account #:

All Questions Must Be Answered Put N/A if not Applicable Use Second Sheet of Paper for Additional Information

Patient (If patient is a minor, use father's information)

Name:	Social Security #:	Birth Date:
Address:	City, State, Zip Code:	
Telephone #	How Long Resided?	Marital Status:
Previous Address:		
Employer & Address:		
Previous Employer & Address		

Dependents Name	Date of Birth	Social Security #	Living In your Household

Nearest Relative Not Living With You:	Phone # :
Address:	Relationship:

Spouse (If patients is a minor – mother's information)

Name:	Social Security #:	Birth Date:
Address:	City, State, Zip Code:	
Telephone #	How Long Resided?	Marital Status:
Previous Address:		
Employer & Address:		
Previous Employer & Address		

FINANCIAL INFORMATION: (Include ALL Household Income)

Household Gross Income $	Monthly Take Home Income $	Other Income $	
Social Security $	Retirement/Pension $	IRA $	
Certificate Of Deposit $	Stocks/Bonds/ Annuities $	Welfare	Food Stamps

Home: Own Renting Buying Other		Monthly Payment $	
Paid To:		Property Value $	Balance Owing $

Vehicles: Year/Make/Model	Monthly Auto Payment	Balance Owed	Paid To

Financial Information (continued)

MONTHLY EXPENSES (Include payments **ONLY** if not deducted by your employer on your payroll check)	**Current**	**Past Due**		**Current**	**Past Due**
Rent or House Payment	$	$	Child Care	$	$
Power	$	$	Phone	$	$
Gas/Oil Heat	$	$	Gasoline	$	$
Water, Sewer, Trash	$	$	Groceries	$	$
Child Support	$	$	Health Insurance	$	$
Auto Insurance	$	$	Life Insurance	$	$
Medications	$	$	Fines/Garnishments	$	$
Auto Payments	$	$	Other_____	$	$

Medical Bills, Credit Cards, Loans, & Other Debts (include any taxes, dues, etc.) **Balance**		**Monthly Owing**	**Payment**
Name	Address, City, State & Zip Code	$	$
Name	Address, City, State & Zip Code	$	$
Name	Address, City, State & Zip Code	$	$
Name	Address, City, State & Zip Code	$	$
Name	Address, City, State & Zip Code	$	$
Name	Address, City, State & Zip Code	$	$
Name	Address, City, State & Zip Code	$	$
Name	Address, City, State & Zip Code	$	$

Release of Information:

I hereby authorize and direct any hospital or physician who has attended me, any and all Idaho County entities, the State of Idaho Department of Health and Welfare, all federal government agencies (i.e., Social Security Administration, Veterans Administration) and all creditors, banks and lending institutions to release any and all information they may have pertaining to me and any member of my family to Teton Valley Health Care for their examination and/or copying thereof, upon their request. In addition, I authorize Teton Valley Health Care to obtain my credit report to verify all financial information. This information includes but is not limited to applications, decisions, records, medical and otherwise, reports, bills and invoices. I further authorize Teton Valley Health Care to release to you whatever information they may have or receive pertinent to any application I have or will make for assistance from any local, state or federal entity. A photocopy of this authorization may be used in lieu of the original.

Signed _____ Date _____

TETON VALLEY HEALTH CARE
Your Healthcare Elevated
120 East Howard Avenue, Driggs, Idaho 83422
208-354-2383 www.tvhcare.org

Financial Information (continued)

1. Proof of all gross (pretax) income for the responsible party. Including paycheck stubs or last year's federal tax return, child support, alimony, or social security income statement; and/or your unemployment compensation letter.
2. Proof of residency, including a copy of one of the following: a gas, electric, phone or cable bill a rent receipt, credit card bill, driver's license or state identification.

By my signature below, I certify that I have carefully read this application and that everything I have stated or provided in any attachment is true to the best of my knowledge and belief. I understand that it is unlawful to knowingly submit false information to obtain financial assistance.

Signature of Responsible Party _____ Date completed _____

If you reported $0.00 income on the first page, please have the Support Statement below completed by the person(s) helping you and/or your family.

Support Statement (To be completed by the person providing support.)

I have been identified by the applicant as the person providing support. Below is a list of all services I provide the applicant.

_____

_____

_____

_____

_____

_____

I hereby certify that all the above information is true and correct to the best of my knowledge and belief. I understand that my signature does not make me responsible for the patient's medical charges.

Signature_____ Date_____/____/_____

Mailing Address_____ City, State, Zip_____

Patient Insurance Information

Did you have health insurance at the time of your services? **YES** **NO** (please circle one)
If **"YES",** please attach a copy of your card, front and back and fill out the following:
Name of insurance company: _____
Policy Number_____ Group Number_____

Insurance Phone Number_____

Hospital Use Only

By my signature I affirm to the best of my knowledge and belief that the information on this application is accurate.

TVHC Representative Signature_____DateCompleted_____