Teton Valley Health Care

Subject: Financial Assistance Program Application

Dear:

Thank you for submitting your financial assistance application. We need the following documents to complete the process of your application.

- ☐ W-2 withholding
- ☐ Pay stubs from all employment during the relevant time
- ☐ Income tax return from the most recently filed calendar
- ☐ Forms approving or denying eligibility for Medicaid and or state-funded medical
- ☐ Forms approving or denying unemployment compensation; or
  Written statement from employers or DSHS employees

You can also include other documents that support your economic situation. We will notify you of our determination in writing.

Please feel free to contact us if you have any questions.

Sincerely,

Patient Financial Advocate
Teton Valley Health Care
(208) 354-6320

Teton Valley Health Care

FINANCIAL ASSISTANCE PROGRAM APPLICATION

Name: _____ Social Security #: _____

Date of Birth:_____ Cell #: _____ Home Phone # **: _____

Mailing Address: _____ Email: _____

City: _____ State: _____ Zip code: _____

How Long Resided:_____ Marital Status:_____

Previous Address:_____

City: _____ State: _____ Zip code: _____

Employer's Name:_____

City: _____ State: _____ Zip code: _____

How long employed: _____ Employers Phone #: _____

Dependents Name	Date of Birth	Social Security #	Living in Household

Nearest relative not living with you:_____ Relationship:_____

Address:_____

City: _____ State: _____ Zip code: _____

Spouse's Name:_____ Social Security #:_____

Date of Birth: _____ Home Phone #:_____ Cell #:_____

Address:_____

City: _____ State: _____ Zip code: _____

How Long Resided:_____ Marital Status:_____

Previous Address:_____

City: _____ State: _____ Zip code: _____

Employer's Name:_____

City: _____ State: _____ Zip code: _____

How long employed: _____ Employers Phone #: _____

Household Gross Income	$	Food Stamps	$
Monthly Take Home Income	$	Stocks/Bonds/Annuities	$
Social Security	$	IRA	$
Retirement/Pensions	$	Welfare	$
Certificate of Deposit	$	Monthly Payment	$
Home: Own Rent Buying Other		Other	$

Paid To:

Property Value $

Remaining Balance $

FINANCIAL ASSISTANCE PROGRAM APPLICATION (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.
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 service? Yes _____ No _____

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: _____

Facility Use Only

TVHC Representative Signature: _____ Date Application Received: _____

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