Community Hospital
2351 G Road
Grand Junction, CO 81505
(970) 242-0920

The following information and documentation is **required** to complete your **Financial Assistance** application. If the information/documentation is not received the financial assistance application will be considered closed and any account balance(s) will be due in full for account(s). Community Hospital reserves the right to decline any request to reopen the application.

YOU MUST PROVIDE THE FOLLOWING:

- Valid Colorado Driver's License / ID for each family member over 18.
- Birth Certificates for all children under 18.
- Social Security card for each family member or a copy of the application.
- Documentation of Legal Immigrant status **(front and back of card).**
- Copies of (all) Health insurance cards **(front and back of card)** .
- Denial letter(s) from Medicaid or CHP+.
- Copies of the most **recent** paycheck stubs for the past 30 days.
- Proof of unemployment income, i.e. the award letter you received.
- Proof of social security Income in the form of a benefit letter.
- **Self Employment only:** Profit/Loss statement, bank account statements for business and 2016 tax returns. Also, complete, sign and date Self Employment worksheet.
- Most **current and complete** bank account statements for **all**: **checking, savings, pre paid bank cards, health savings accounts, CD's, annuities, pensions. If receiving monthly payments from a 401K's & IRA's.**
- Complete Federal **(1040)** Tax & W- 2's. (Current year)
- Most recent Home Loan/Mortgage statement.
- Rental/Lease agreement **(must state address, cost per month, landlords signature and date).**
- Sign and date CICP client's responsibilities form.
- Complete & sign financial statement.

The documentation above is required to be returned to Community Hospital main entrance in person or by mail.

All documentation must be COPIED. We will accept NO original documents.

If you have questions or need assistance please call: (970) 644-3144, (970) 644-3156 or Oncology at (970)644-3193

Thank you,

Financial Counselor
Community Hospital

Colorado Indigent Care Program (CICP)
Client's Responsibilities

CICP Clients Shall:

1. Acknowledge that the CICP is not health insurance, does not offer a specific benefit package, is not an entitlement to medical benefits and that there are limitations to services discounted.
2. Acknowledge that discounted CICP health care services vary by provider location.
3. Give the CICP provider all the necessary financial information and documentation needed to complete the application.
4. Shall not give false information with the intent to commit fraud.
5. Tell the CICP provider if a CICP financial rating was issued by another provider and notify the CICP provider within 15 days if the CICP rating is disputed.
6. Be responsible for paying any money owed on time and as required or work with the CICP provider to make payment arrangements.
7. Notify the CICP provider promptly of changes in resources, income and all other household changes that may affect the CICP rating.
8. Communicate any information, concerns and/or questions related to the financial screening to the appropriate representative.
9. Respect the property of the CICP provider, fellow clients and others.
10. Follow all other rules and regulations of the CICP provider's location relating to respectful treatment and rights of other clients and provider staff.

Client's Name (print): _____ **Date:** _____

Client's Signature: _____

Account(s) # _____

COMMUNITY HOSPITAL
FINANCIAL STATEMENT

Please complete sign, date and return this statement with all documentation

1._____
Name (head of household) Soc Sec # Date of Birth

2._____
Spouse Soc Sec # Date of Birth

3._____
Mailing Address Street Address (If different from mailing)

4. **Home Phone _____ Day Time Phone _____ Cell Phone_____**

5._____
Employer Name Address Occupation Phone # #of Years

6._____
Spouse Employer Address Occupation Phone # #of Years

7. **E-mail Address:**_____

Family Status (check one)_____Single _____Married _____Separated _____Divorced _____Widow(er)_____Common law

Number of persons in your household that you support: _____Adults _____Children _____Parents _____Grandchildren

Name of Additional Family Members Not Listed above:	**Relationship**	**Soc Sec #**	**Date of Birth**	**Insurance**

Employment

How are you paid? ☐ **Weekly** ☐ **Bi-Weekly** ☐ **Semi-Monthly** ☐ **Monthly**
How is you spouse paid? ☐ **Weekly** ☐ **Bi-Weekly** ☐ **Semi-Monthly** ☐ **Monthly**

Are you? ☐ **Full Time** ☐ **Part Time** ☐ **Seasonal** **From _____ To _____**
Is your spouse? ☐ **Full Time** ☐ **Part Time** ☐ **Seasonal** **From _____ To _____**

Financial Statement

Source of Gross Income	Head of Household	Spouse		Value		
Monthly Wages			Present Home			
Commissions / Tips			Checking Account			
Self Employment			Savings Account			
Unemployment			CD's/Money Market			
Social Security/SSI/SSDI			Pre-paid Bank Card			
OAP (Old Age Pension)			Health Savings Accounts			
Retirement / Pension			Whole Life Insurance			
Workman Compensation						
Rental Income						
Alimony/Maintenance						

I/WE HERE BY CERTIFY THAT THE INFORMATION LISTED HERE IN IS TRUE AND CORRECT TO THE BEST OF MY/OUR KNOWLEDGE AND GIVE COMMUNITY HOSPITAL MY/OUR PERMISSION TO VERIFY ANY INFORMATION LISTED. I WILL REPORT ANY CHANGES IN MY SITUATION WITHIN 90 DAYS.

Date _____ Signature _____

Date _____ Signature _____

Self-Employment Income

(Attached proof of Expenses)

Do you operate your business from your home? _____

Square footage of your home_____

Square footage used for home business_____

Hours per week worked out of your home_____

	Monthly	Annualized
Revenue: Gross Business Income	_____	_____
Business Property Expenses:		
Mortgage/Rent of Business Property	_____	_____
Utilities	_____	_____
_____	_____	_____
_____	_____	_____
Other Expenses:		
Advertising	_____	_____
Business Phone	_____	_____
Business Taxes (non-personal)	_____	_____
Fuel for Business-related Travel	_____	_____
Gross Wages	_____	_____
Business Insurance	_____	_____
Legal Fees	_____	_____
License/Certification Fees Paid	_____	_____
Merchandise/Cost of goods	_____	_____
Office Supplies	_____	_____
Repairs/Upkeep of Equipment	_____	_____
Tools/Equipment	_____	_____
_____	_____	_____
_____	_____	_____
Total Expenses:	_____	_____
Net Profit	_____	_____

Applicant Signature_____ Date:_____