Stormont Vail Health

FINANCIAL ASSISTANCE APPLICATION

Stormont Vail Hospital and Cotton O'Neil Clinic Account

Guarantor # _____
This information can be found on the upper right hand corner of your statement

Guarantor Name _____
This is the name of the person to whom the statement is mailed

General Information

Patient Name_____ _____ _____
(Last) (First) (M.I.)

Person Responsible for Payment _____ Relationship to Patient _____

Address _____

City _____ State _____ Zip Code_____

Please provide the phone number where you can be reached in the event we need to contact you (____)_____

Financial Information

Total Monthly Income		**Documentation listed below is required for proof of ALL Financial Information**
Gross Monthly Income	$	Most recent Federal Income Tax forms (all forms with IRS) with W2s – If you have not filed Federal Income taxes, please explain why
Gross Monthly Income (spouse)	$	Pay stubs for the last month for you and your spouse
Monthly Child Support received	$	Court document indicating the amount of child support
Monthly alimony received	$	Court document indicating the amount of alimony
Social Security received	$	Social Security benefits letter/statement
Disability received	$	Disability benefits letter/statement
Unemployment received	$	Unemployment benefits letter
Interest Income, dividends, etc.	$	Interest and dividends income statement
Pension Income	$	Pension benefits letter
Other income	$	Most recent statements for other resources (CDs, money markets, stocks, bonds, mutual funds, etc.)
Total amount in Savings Acct	$	Copies of most recent statement(s) for savings account
Total amount in Checking Acct	$	Copies of most recent statement(s) for checking account
Total amount in other resources	$	Copies of most recent statements

Number of persons supported by Total Monthly Income _____

If different from Federal Tax Form, please explain briefly _____

I certify that the above information is true and accurate to the best of my knowledge. I understand that if I submit false information I will not be eligible for Financial Assistance. I certify that I meet the eligibility requirements needed to apply for Financial Assistance, as described on the instruction form.

Signature _____ Date _____

Return this form along with **ALL** required documents above. Failure to complete this form in full and to provide required documentation as proof of ALL Financial information **WILL** result in Financial Assistance denial. Further information may be requested pending consideration of Financial Assistance.

All required information is due back within 14 days of receipt of request. If you have any questions call Customer Service (785) 354-1150, (800) 637-4716, or email billinghelp@stormontvail.org