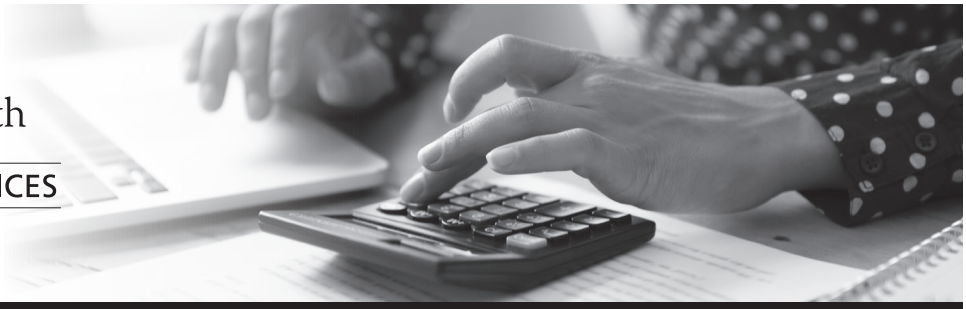
Campbell County Health

PATIENT FINANCIAL SERVICES



Applicant Information

Guarantor Name _____
Last *First* *M.I.*

Guarantor Date of Birth _____ GUAR# _____

Spouse _____
Last *First* *M.I.*

Spouse Date of Birth _____ GUAR# _____

Address _____
Street Address *Apt/Unit #*

_____
City *State* *ZIP Code*

Phone _____ Email _____

Number in household _____ SSN _____ Spouse SSN _____

Names/ages of household members _____

_____

Presumptive eligibility: Do you receive assistance from? (Check all that apply, and please provide proof of participation.)

☐ Medicaid/CHIP ☐ SNAP/LIEAP/WAP ☐ Homeless Shelter ☐ Section 8 Housing ☐ Other

Financial Information

	Guarantor / Frequency	Spouse/Partner / Frequency
INCOME **Gross Wages /** **Unemployment / Work Comp**	**$** / **Employer:**	**$** / **Employer:**
SSI / SSDI Benefits	**$**	**$**
Child Support	**$**	**$**
Retirement / Pension	**$**	**$**
Other Income	**$**	**$**
Bank Name:	**Checking: $** **Savings: $**	**Checking: $** **Savings: $**

Disclaimer and Signature

I certify that my answers are true and complete to the best of my knowledge. I will apply for any state, federal, or local assistance for which I may be eligible to help pay for this hospital bill. I understand that the information provided may be verified by the hospital, and I authorize the hospital to contact third parties to verify the accuracy of the information provided in this application. I understand that if I knowingly provide untrue information in this application, I will be ineligible to receive financial assistance.

Guarantor Signature _____ Date_____

Spouse/Partner Signature _____ Date_____

Application Documents

Please provide the following documents along with your application to determine eligibility.

- ☐ Two most recent paystubs with gross year-to-date earnings.
- ☐ Most recent tax return.
- ☐ All checking and savings statements (with transactions).
- ☐ SSI/SSDI benefits letter (if applicable).
- ☐ Proof of child support (if applicable).
- ☐ Medicaid denial letter.
- ☐ Work Comp/Unemployment benefit letter (if applicable).
- ☐ If unable to provide requested information, please write a letter explaining your financial situation.

Financial assistance expires after 90 days from approval date.
Adjustments will be given to active and current accounts only.

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cchwyo.org