Financial Assistance Application

How to Apply . . .

In order for us to process your application, you must submit ALL of the documents listed below. Any additional documents requested must be received in the Patient Financial Services department within 15 business days. The information received will remain confidential. The collection process will continue until your financial assistance status is determined.

Required Documents . . .

- ❑ The completed signed financial assistance application.
- ❑ A copy of your signed prior year's tax return, including schedule C if self-employed, or 1099 form if retired and on Social Security. (If you do not have a copy of your tax return, you may obtain this information from the IRS by calling 1-800-829-0922)
- ❑ If employed, copies of four current, consecutive paycheck stubs for patient and spouse.
- ❑ If applicable, copies of your Social Security check, disability check, unemployment check or an award letter for each person listed on the tax return. If unemployed please include the date of your last day worked.
- ❑ Complete copies of last three detailed bank statements showing all transactions for all open checking and savings accounts.
- ❑ Copies of any outstanding medical bills, including doctor bills, ambulance, etc.
- ❑ **Colorado patients only** are required to complete the Colorado Indigent Care Program (CICP) prior to applying for financial assistance.
  NOTE: *"Failure to provide information or failure to complete the application" is not acceptable.*
- ❑ A copy of the State Assistance program (Arizona – AHCCCS / California - Medi-Cal / Other states - Medicaid) decision notice.
  NOTE: *"Failure to provide information or failure to participate in the interview" is not acceptable and cannot be used in this application.*

Completing the application is not a guarantee you will be approved for the Financial Assistance Program. Approval is based on verified annual household income and family size in accordance with the expanded Federal Poverty Guidelines established by the Centers for Medicare, Medi-Cal and Medicaid (CMS) specifically for the state of Colorado, Arizona, Wyoming, Nebraska, Nevada and California.

You will be sent a notification letter after your financial assistance status is determined.

If you need further assistance or have any questions, you may contact me at (480) 684-5544 or toll free at 1-866-640-3600 option 2, Monday through Friday, 8:00 a.m. to 5:00 p.m. Thank you.

Sincerely,

Diane Newell
Patient Financial Services
Banner Health

Financial Assistance Application

Please fill out all pages completely and print clearly. ***Completing the application is not a guarantee you will be approved for financial assistance and our collection process will continue.***

Return the signed and dated application to:
Banner Patient Financial Services,
PO Box 18 Phoenix, AZ 85001.

Patient Information

Facility: _____ Account Number: _____

Assistance Requested By_____ Relationship Status _____ Age _____ Date_____

Patient Name _____ Social Security # _____

Street Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Email Address _____

Employer _____ Occupation _____

Employer Phone _____ Length of Employment _____ Gross Salary per Month $_____ Gross Salary per Year $_____

If Unemployed list last date worked: _____

Spouse Information

Spouse Name _____ Social Security #_____

Street Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Email Address _____ Marital Status _____ Age _____

Employer _____ Occupation _____

Employer Phone _____ Length of Employment _____ Gross Salary per Month $_____ Gross Salary per Year $_____

If Unemployed list last date worked: _____

Household Information

Please list all household members (include yourself)

Name	Relationship	Age	Income	Dependant
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

PLEASE COMPLETE AND SIGN THE REVERSE SIDE

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PO Box 18 Phoenix, AZ 85001.

Financial Information

Income Sources	Monthly	Yearly
Gross Salary	$_____	$_____
Social Security Income	$_____	$_____
Food Stamps	$_____	$_____
Unemployment Compensation	$_____	$_____
Workers Compensation	$_____	$_____
Child Support	$_____	$_____
Veterans Assistance	$_____	$_____
Pensions	$_____	$_____
Income from Dividends, Interest	$_____	$_____
Scholarships, Grants, Student Loans	$_____	$_____
Public Assistance	$_____	$_____
Permanent Fund Dividend	$_____	$_____
Other Income	$_____	$_____
Total Income	$_____	$_____

I,_____ , hereby request that Banner Health make a determination of my eligibility for financial assistance. I understand that:

• My application will be reviewed for final determination only after all other possible payment resources have been considered (such as Medicaid, Veterans Assistance, Indian Health Services, Victims of Violent Crimes or Social Security Income) which may assist me in support of medical expenses. Financial Assistance will be reversed if I become eligible for or receive any third-party funding source to include liability or personal injury protection funding.

• I am required to report all income received, including gross taxable and non-taxable income which supports annual income.

I further understand that all disclosed income will be considered for determination of Financial Assistance and will not be released without proper consent.

• Financial assistance can only be applied to Banner Health Hospital accounts.

• All of the information which I have provided to Banner Health Hospital Billing Office for myself and on behalf of my family is true and correct to the best of my ability. I further understand that if any of the information is found to be false, my Financial Assistance application may be denied.

• **Colorado patients only** are required to complete the Colorado Indigent Care Program (CICP) prior to applying for financial assistance.

NOTE: *"Failure to provide information or failure to complete the application" is not acceptable.*

☐ Check this box if you were not required to file Federal Income Tax Returns and supporting documentation has been provided.

Signature _____
Date_____

Additional Patient Comments

Additional Comments _____

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