EPMC
Financial Assistance Application

Estes Park Medical Center
PO BOX 2715
Estes Park, CO 80517
(970)586-2317 Fax (970)586-5757

Patient Name:_____ **Patient Account #(s):**_____

Responsible Party Name (if patient is a minor):_____ **SS#:**_____

Spouse's Name:_____ **SS#:**_____

Physical Address:_____ **SS#:**_____

Mailing Address:_____ **Home Phone#:**_____

_____ **Mobile Phone#:**_____

Number of family members living in the home (spouse and dependents):_____

Have you recently made, or plan to make an application for Medicaid and/or Medical Assistance?: Yes _____**No** _____

Date of Application:_____

INCOME VERIFICATION (List all persons in household who are employed)

Name	Relationship to Patient	Employer's Name & Address	Monthly Income	
			Gross	Net
			$	$
			$	$
			$	$
			$	$

OTHER INCOME (List monthly accounts)

Name	Relationship to Patient	Child Support	Unempl. Comp.	TANF	Social Security	SSI	VA	Interest/Rental Income
		$	$	$	$	$	$	$
		$	$	$	$	$	$	$
		$	$	$	$	$	$	$

ATTACHMENT B: FINANCIAL ASSISTANCE APPLICATION

RESOURCES (List all resources owned by members of the household and value)

Resource	Bank or Company	Value	Owner
Checking Account			
Savings Account			
Certificates of Deposit			
Trust Fund			
Stocks or Bonds			
Retirement Account			
Other			
Mutual Funds			

Personal Property	Description	Mortgage/Loan	Payments
Primary Residence			
Rental Property			
Automobiles (list below)			
Recreational (boats, campers, ATV, motorcycles, etc.)			
Livestock			

EPMC
Financial Assistance Application

Name:_____

MONTHLY EXPENSES	MONTHLY PAYMENTS	CURRENT BALANCE
Food	_____	_____
Rent/House Payment	_____	_____
Gas – House	_____	_____
Electricity	_____	_____
Water and Sewer	_____	_____
Cable Television/Satellite	_____	_____
Telephone (including wireless)	_____	_____
Gas (Car)/Transportation	_____	_____
Car Payment	_____	_____
Car/House Insurance	_____	_____
Health/Life Insurance	_____	_____
Prescriptions	_____	_____
Doctors/Healthcare Providers	_____	_____
Credit Cards	_____	_____
Other	_____	_____

Total Monthly Income:_____

Total Monthly Expenses:_____

Signature:_____

Must submit:
Current and prior year's household Federal Income Tax Return
Most recent 4 employer paycheck stubs
Copy of all bank statements for the past three months
Copies of one month's expense statements
Personal letter of financial hardship

This information obtained will be kept confidential and used only for Financial Assistance determination.