SCL Health

SCL Health
500 Eldorado Blvd. Bldg. 6 Suite 6300
Broomfield, CO 80021-3408

Thank you for choosing SCL Health for your healthcare needs. Sisters of Charity of Leavenworth Health System is proud to provide quality and affordable healthcare for the community. We are here to assist those who are in need of financial assistance and to help those who may have questions or need guidance making health care choices for themselves and their families.

SCL Health has a program to help patients who need financial assistance with paying all or part of their bills. To apply for this program, please fill out the information on the attached financial assistance application.

In order to process your application, we also require supporting documentation. A list of required documents can be found on page four (4). This information must be received within 15 days from the date of this letter if received in person. If you feel that you need to explain your situation further in order to obtain financial assistance, additional space has been provided at the end of the application.

It is important that applications be filled out completely and returned with required documents. Failure to do so will slow down processing the application and possibly be reason for denial. Applications received without a signature will be denied.

If for any reason the above information cannot be obtained, please call the Revenue Service Center at 303-813-5400 or 1-866-665-2636 between the hours of 8 a.m. and 4:30 p.m. We will be more than happy to assist you.

Once a decision has been made regarding your account, you will be notified by a mail with the results of our decision.

Sincerely,

Financial Coordinator
SCL Health

Health Care Financial Assistance Application

General Information

Patient Name_____ Account # _____

Social Security Number _____ Date of Birth _____

Address _____

City _____ State_____ Zip_____ County _____

Home Phone # _____ Cell Phone # _____ Work Phone #_____

Email _____

☐ Single ☐ Married/Significant Other ☐ Divorced/Separated ☐ Widow/Widower

Responsible Party Name _____ Relationship _____

Social Security Number _____ Date of Birth _____

Address _____

Home Phone # _____ Cell Phone # _____ Work Phone # _____

Spouse's Name_____

Social Security Number_____ Date of Birth _____

Address _____

Home Phone # _____ Cell Phone # _____ Work Phone #_____

Name(s) and age(s) of dependents living with you for whom you are responsible. Please include DOB:

_____ _____

_____ _____

_____ _____

Financial Assistance Application

INCOME

Prior year's **AGI** (Adjusted Gross Income) reported to the IRS (found on Form 1040) _____
If you did not file a tax return, please explain _____
_____

Current Employer _____

Address _____

Phone Number_____ Occupation _____

Length of Employment _____years _____months Full Time / Part Time _____
Number of hours scheduled to work each week _____

If unemployed, date of unemployment: _____ Are you receiving unemployment Yes / No _____
If *YES* – Beginning date_____ Amount receiving weekly_____

Spouse / Significant Other's Current Employer _____
Address _____

Phone Number _____ Occupation _____

Length of Employment _____years _____months Full Time / Part Time _____
Number of hours scheduled to work each week _____

If unemployed, date of unemployment: _____ Are you receiving unemployment Yes / No _____
If *YES* – Beginning date_____ Amount receiving weekly _____

Income on a Monthly Basis	**Yours**	**Spouse**	**Assets**	**Value/Balance**
Gross Pay			Current Home	
Alimony/ Child Support			Other Property (land, investment, rental, etc.)	
Social Security			Vehicle(s)	
Unemployment / Work Comp			Investments - Stocks, Bonds, Mutual Funds, 401k, IRA, Annuities	
Retirement / Pension			Savings Account I.	
Interest / Rental			Savings Account 2.	
Public Assistance			Checking Account	
Other			Other	
Monthly Total			Other	

(Office use only) Annual Total_____

EXPENSES

Name of Mortgage Holder or Landlord_____

Address_____

_____

	Monthly Payment	Outstanding Balance	Current Yes / No
Mortgage / Rent			
Home Owner's /Renter's Insurance			
HOA			
Telephone - home			
Cell Phone			
Electricity			
Gas			
Water			
Cable / Satellite / Dish			
Auto Loan			
Auto Loan			
Auto Insurance			
Transportation - Gas			
Life Insurance			
Health Insurance			
Medical Bills			
Prescriptions			
Food			
Child Care			
School Expenses / Loans			
Alimony / Child Support			
Credit Card Bills			
Internet			
Other			
Other			
Monthly Total			

(Office use only) Annual Total_____

OTHER

Do you receive food stamps? □Yes □No

Do you have medical benefits? □Yes □No

If no, have you applied for Medicaid? _____ Date Applied_____

If benefits were denied, what reason was given? _____

_____

Date Medicaid was denied _____

REQUIRED DOCUMENTS:

- **Completed, signed and dated application**
- **Copy of your last 3 months of pay stubs for you, spouse and/or significant other**
- **3 months bank statements (includes personal/savings/business accounts, displaying account owner's name and account number**
- **Copy of award letter(s) – Unemployment, Social Security, etc. displaying monthly benefit**
- **Child Support / Court Ordered Maintenance**
- **Copy of prior year's tax returns (all pages) must be submitted with this application. Cannot accept W2 forms.**
- **If unemployed and / or living with friend or family, page three (3) "Expenses" must be filled out**

If unemployed and living with family or friend

Page three (3) of the financial application must be completed showing what the monthly mortgage/rent, electric/gas and cable statements reflect. (Please do not provide receipts)

If Applicant of Spouse is self-employed:

Must provide copy of the business ledger for the last three (3) months

Non-US Residency

Provide a copy of your photo ID. Passport, Visa, etc.

We will deny applications that are incomplete.

Your signature is required to complete this application.

My signature attests that the information I have provided on this form is accurate and true to the best of my knowledge. I understand that SCL Health System requires verification of income before any determination is made. I also understand that my credit may be accessed, at no expense to me, to verify the above information.

Signature_____ Date _____

Please use space below if needed:

_____
_____
_____
_____
_____
_____
_____
_____

Office Use Only:

Family Size_____ Income_____ Yearly Expenses_____ Poverty Level_____

Out Pt. Responsibility_____ In Pt. Responsibility _____ Clinic Responsibility_____Level:_____

Special Notes: _____

_____

_____

Financial Coordinator Name: _____ Approved Denied
Decision Date _____