Gila Regional Medical Center

Attachment B

GRMC Financial Assistance Program Application			
Patient Account Number			Date of Healthcare Service on Billing Account
Patient Last Name	Patient First Name	Patient Social Security #	Patient Date of Birth
Guarantor Last Name (If Different)	First Name	Guarantor Social Security #	Date of Birth ( )
Guarantor Home Address			Home Telephone Number
City	State	Zip Code	
Guarantor's Employer Name	Guarantor's Annual Income $		Guarantor Job Function/Department
Do you have Health Insurance? ___Y ____N Insurance_____ Policy #_____			Group #_____ ( )
Guarantor's Employer address			Guarantor's Employer Telephone
City	State	Zip Code	
Spouse's Employer Name	Spouse's Annual Income		Spouses' Job Function/Department
Does your Spouse have Health Insurance ___Y ____N Insurance_____ Policy#_____			Group#_____ ( )
Spouse's Employer Address			Spouse's Employer Telephone
City	State	Zip Code	

People in Household			
Name	Date of Birth	Employer	Employer Telephone number
1)			
2)			
3)			
4)			
5)			
6)			
7)			
8)			

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GRMC Financial Assistance Program Application (Continued)

Please complete the table below as completely as possible.

Income Analysis		Qualified Monetary Asset Analysis	
In order to determine your eligibility for the GRMC Payment Assistance Program, please provide us with information about your annual before-tax household income.		*Please do not include any funds held in tax exempt/deferred accounts such as 401K savings accounts, 403B savings accounts, and IRA savings accounts.*	
Job Income	$_____	Checking Account(s) $_____	
Spouse Job Income	$_____	Savings Account(s) $_____	
Business Income	$_____	Stocks, Bonds & CDs $_____	
Rental Income	$_____	Other Monetary Assets	$
Interest/Dividend Income	$_____	**Total Qualified Savings** **$_____**	
Social Security Income	$_____		
Alimony or Support Payments	$_____		
Other Income	$		
Total Income	**$_____**		

IMPORTANT PLEASE READ: THIS FORM MUST BE ACCURATELY COMPLETED AND ALL DOCUMENTATION REQUESTED SUBMITTED WITHIN THIRTY (30) DAYS OF THE DATE OF YOUR HEALTH CARE SERVICE IN ORDER FOR YOUR APPLICATION TO PARTICIPATE IN THE FINANCIAL ASSISTANCE PROGRAM TO BE CONSIDERED. APPLICATIONS THAT ARE NOT COMPLETED WITHIN THIRTY (30) DAYS WILL BE DENIED.

In order to determine whether you meet the criteria for financial assistance, it is required that you submit this fully completed application and provide the documentation and information requested to demonstrate financial hardship. Please complete the attached application and return it with all of the following items. If you are unable to supply one of the documents, please submit a statement explaining why you cannot provide the information.

1. **Proof of Identity –** One of the following: Photo I.D
   - Copy of Social Security Card
   - Copy of state issued driver's license
   - Other photo ID
   - Proof of State of New Mexico legal residency
2. **Proof of Monetary Assets –** All of the following (if applicable):
   - Last two months checking account statements
   - Last two months of savings account statements
   - Documentation about stocks, bonds, and/or CDs
   - Money market accounts
   - Annuities
   - Pensions

   2 Bank statements of checking and savings
3. **Verification of Current Address –** One of the following:
   - Rent receipt
   - Utility bill
4. **A copy of a state Medicaid decision/denial notice.**
5. **Proof of Income**

6. 2023 Taxes

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- If employed, include a copy of prior year tax return, including W-2 or check copies or check stubs from each of the prior three months.
- If receiving public assistance, include copies of public assistance checks from each of the prior three months or award letter (i.e., disability, unemployment pay stubs, or social security benefits.)
- If self-employed, include Schedule C of prior year tax return and a quarterly accountant report with a written statement declaring gross income received during the last three months.
- If not receiving a consistent income, write a brief paragraph on a separate paper stating your financial situation over the last three months. Explain how or from what source you are receiving monies to pay for your basic living expenses such as food and housing.
- If dependent upon another individual's financial support, include a "letter of financial support."

6. **Proof of Unpaid GRMC Expenses.** Applications must include documentation of unpaid GRMC expenses. Any unpaid GRMC expenses must be documented by a billing invoice and a balance due statement.

By signing below, you indicate you have fully read and understand this application and that you desire to be considered for participation in GRMC's Financial Assistance Program. You also certify, represent and warrant that all the statements made on this Application are true and complete to the best of your knowledge. You also unconditionally grant GRMC authorization to verify the information that was submitted with this Application, to check references and to obtain any additional information necessary including, but not limited to a credit history in order to evaluate this Application for participation in GRMC's Financial Assistance Program. ***You also understand that if the information you submitted cannot be verified, or the documents GRMC requested were not provided, or this Application is not completed within thirty (30) days from the date of the health care services for which you are requesting financial assistance under this Program, your Application will be denied and you will be responsible for the billing charges.***

_____ _____

Signature of Person Responsible for Bill (Guarantor) Date

For internal GRMC Patient Financial Service Department use only.

1) Did patient fully and accurately complete application within thirty (30) days of service? Y_____ N _____.

2) Does patient meet Program residency criteria? Y_____ N_____.

3) Does patient's healthcare service, for which a discount is requested, meet the Program's medical necessity criteria? Y____. N_____; and were the healthcare services GRMC inpatient, ER, EMS services? Y_____N_____.

4) Does patient meet the Program's financial eligibility criteria? Y_____ N_____.

If "yes" is answered to **all** questions above (1-4), calculate the discount percentage according to the Program policy and send the patient the Determination Notice of Approval. Apply the Calculated Discount Amount to the patient account. Calculated Discount Amount = _____.

If "no" is answered to any of the questions above (1-4) the patient does NOT qualify for the Program discount. Send the patient the Determination Notice of Denial and determine if the patient qualifies for a self-pay discount? Y_____ N_____.

If "yes", calculate Self Pay Discount and have patient sign Self Payor Discount Form. Calculated amount = _____.

If the patient is a Self Payor was payment plan offered to patient? Y_____ N_____.