



Powell Valley Healthcare

FINANCIAL ASSISTANCE PROGRAM

To ensure access to health care services provided by Powell Valley Health Care, Inc., a Financial Assistance Program is provided for eligible patients who are otherwise unable to pay for these services. If approved, Financial Assistance will cover accounts up to 180 days from discharge.

Financial Assistance Program eligibility is based on Federal Poverty Income Guidelines, and financial ability to pay as determined through an application process. Elective procedures do not qualify for the Financial Assistance Program.

The following documents must be included with your completed application:

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- Documentation of income for 3 months – current pay stubs
- Completed Financial Statement - attached
- Tax Return – Including ALL pages and ALL Applicable W-2's
- All documentation regarding unemployment and/or workers compensation, alimony, child support, WIC, Food stamps and/or other financial support.
- Copy of the last 3 months bank statements.
- Letter of Denial from Wyoming Public Assistance Program

CALL **1-855-294-2127** TO APPLY BY PHONE FOR WY MEDICAD
Or login at http://www.wesystem.wyo.gov/AVANCE_ONLINE_APP

If you think you may be eligible for the Financial Assistance Program, you may request an application at the hospital business office, registration office, clinic office or online at www.PVHC.org.

A written determination of your eligibility will be provided within 30 days of receipt of the completed application with all necessary supporting documentation.

To be eligible for 100% Financial Assistance, household income must be at or below the following Federal poverty guidelines.

<u>Household Size</u>	<u>Income</u>
1	\$12,140.00
2	\$16,460.00
3	\$20,780.00
4	\$25,100.00
5	\$29,420.00
6	\$33,740.00
7	\$38,060.00
8	\$42,380.00

Add \$4,320.00 for each additional family member

Households that fall above the Federal Poverty Guidelines, but below 200% may be eligible for Financial Assistance based on a sliding scale.

<u>Household Size</u>	<u>Income</u>
1	\$24,280.00
2	\$32,920.00
3	\$41,560.00
4	\$50,200.00
5	\$58,840.00
6	\$67,480.00
7	\$76,120.00
8	\$84,760.00

Add \$8,640.00 for each additional family member

FINANCIAL ASSISTANCE APPLICATION

Applicant (Guarantor) Information:

Name: _____

Address: _____

City/State/ZIP: _____

Phone Number: _____ Social Security Number ____ - ____ - _____

Account(s) for which assistance is being requested:

Date of Service	Account #	Patient Name	Amount
TOTAL			

Have you filed taxes, or were you claimed as a dependent in the past 2 years?

If so, attach a copy of all pages of the return with all W2s or 1099s.

Yes

No

Do you or anyone in the household run a small business, farm, or ranch?

If so, attach income statements and balance sheets for the previous 3 months.

Yes

No

Household Size: (must be able to provide legal proof of member in household: i.e. tax return, court documents, marriage license, etc.)

#	Name	Relationship to Applicant	Date of Birth	Income Source

_____ Total number in household

Household Income: (ALL household income must be reported)

Type	Monthly Amount	Annual Amount
Applicant Gross Wages		
Spouse Gross Wages		
Social Security		
Pension/VA/Railroad Retirement		
Workers Compensation		
Unemployment		
Child Support/Alimony		
Investments Income		
Other:		
Total:		

Expenses

Type	Monthly Amount	Annual Amount
Rent/Mortgage Payment		
Utilities		
Groceries		
Insurance		
Clothing		
Auto - Gas/Oil/Repairs		
Medical/Dental		
Other:		
Other:		
Total:		

Assets	
Cash on hand:	
Bank Name:	
Checking Account number:	
Savings Account number:	
Cash Value of Life Insurance:	
Home Market Value	
Other Real Estate Value	
Automobiles/RVs/ATVs:	
Other Investments:	
Personal & Other Misc.	
Total:	

Liabilities	
Home Mortgage Balance:	
Other Real Estate Balance:	
Credit Card/Loan Balances:	
Medical/Dental Balances:	
Other Debt:	
Total:	

Net Worth	
Total Assets:	
(minus) Total Liabilities:	
Net Worth:	

*Attach Small Business Balance Sheet when appropriate

I hereby request Powell Valley Healthcare, Inc. provide services to me, or my family member, without charge, or at a reduced charge, as may be determined in processing this application. I represent under oath, that I am unable to pay for services requested, and that all of the information submitted is complete and accurate, and may be subject to verification and review by state, federal and other enforcement agencies as required by law. I agree to provide to Powell Valley Healthcare, Inc. such additional information, as may be reasonably required, in order to substantiate my income, financial position, and ability to pay for services provided. I agree to release to PVHC, their agents, and their employees from all liability arising out of their responsible efforts to verify the information I have provided as a part of this application. I understand that my credit report may be used to verify this information. If I am entitled to any action or settlement from third party payers, I will take any action necessary or requested by Powell Valley Healthcare to obtain such assistance and will assign to PVHC and upon receipt, will pay PVHC all amounts recovered up to and the total amount of the outstanding balance on my account.

Signature: _____ **Date:** _____

NOTE: Application must be returned by _____ to ensure eligibility!

HOSPITAL USE ONLY	
Date Application Provided Guarantor: _____	Date Application returned: _____
Assistance Eligibility Level: _____%	Assistance \$ applied to accounts: \$ _____
Balance of accounts after Assistance – Established on Payment Plan:	\$ _____
Authorized Signature: _____	Date: _____