PRIMEHEALTH
WHERE CARE COMES TOGETHER

Financial Assistance Eligibility Application

Thank you *for your interest in becoming a patient at PrimeHealth+ (PH+). You are encouraged to apply for financial assistance, regardless of your insurance coverage.*

The attached forms are part of the application process to determine your eligibility for the Sliding Fee Discount Program or other financial assistance programs that you may qualify for. It is important you read all of the forms and attach the required documents.

1. **ID:** Please bring a form of identification for ALL household members that are applying for services. Examples of approved ID: Colorado ID, passport, other state ID, birth certificate, ID from your country, school ID, permanent resident card.
2. **Earned Income:** Please bring any one of the following for all employed family members:
    - Proof of income for last 30 days (pay stubs)
    - Income verification from your employer
    - If no income, talk with our Financial Assistance Specialist
    - Self-employed: One month of Profit & Loss Statement
3. **Unearned Income:** Please provide copies of these unearned incomes if this applies to you:
    - Unemployment
    - Worker's Compensation
    - SSI
    - Disability Benefits
    - Pensions/Retirement
    - Rents, Alimony
4. **Medical and/or Dental Insurance Cards:** Please provide copies of front and back of cards.

If you have any questions regarding the application or documents requested or to speak to our Financial Assistance Specialist, please call the PrimeHealth+ Financial Assistance Specialist at 970.200.1647 or 970.200.1654. You may also ask questions or return forms via email: Financial.Assistance@PrimeHealthPlus.org. Once your application is processed, we will contact you to let you know if you qualify for the Sliding Fee Discount Program. We will mail your card to you. Thank you again for contacting PrimeHealth+. We look forward to serving you and all of your health care needs.

PrimeHealth+ welcomes Medicaid, Medicare, Medicare Advantage, Rocky Mountain Health Plans, other commercial plans, Delta Dental, and self-pay/uninsured. Financial Assistance Eligibility is based on family size and income.

Mail or drop off this Financial Assistance application to any of our locations:

526 29 ½ Rd., Grand Junction, CO 81504
(Financial Assistance Specialist is here)

510 29 ½ Rd., Grand Junction, CO 81504

2139 N. 12th St., Grand Junction, CO 81501

87 Merchant Dr., Montrose, CO 81401

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Today's Date:		Current Primary Doctor:		
PATIENT INFORMATION				
Last Name:		First Name (Legal)		Middle Initial:
Mailing Address:		City:	State	ZIP:
Date of Birth:	Social Security Number	Marital Status		
		Single Married Divorced Widowed Civil Union		
Sex (Circle):	Male	Female		
Home Phone:		Cell Phone:	Employment Status:	
Employer:			Work Phone:	
Race (Circle):			Primary Language:	
Alaska Native American Indian Asian Black/African-American Hawaiian Native Pacific Islander Patient Refused Unknown White Other _____			Ethnicity (Circle):	Hispanic Not Hispanic Prefer Not to Answer
Housing Status: (Circle):		Public Housing (Circle):	Location (Circle):	
Not Homeless Homeless		No Yes	Lincoln—Bunting Lincoln—North Courtyard Bookcliff Other: _____	
Name in case of emergency:		Relationship:	Phone in case of emergency:	
Preferred Pharmacy:				
Email Address:				
Other notes:				

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Person Responsible for Payment		
Last Name:	First Name:	Middle Initial:
DOB:	Social Security Number:	Relationship to Patient:
Mailing Address:		
Home Phone:	Cell Phone:	
Employer:	Work Phone:	
Insurance		
Type of Insurance/Sliding Scale:		
Primary Insurance:	Group Number:	
Address:	Policy Number:	
Subscriber/Insured Name:	Subscriber DOB:	Subscriber Social Security Number:
Relationship to Patient:	Subscriber Employer:	

Household Members								
	Family Member's Name	**Social Security #**	**DOB**	**Male or Female**	**Relationship**	**Medicaid # or CHP #**	Medicare? **Yes/No**	Name of Private Insurance
1.								
2.								
3.								
4.								
5.								
6.								
7.								
8.								

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Over the past 24 months, have you (patient) or a member of your family:

- Been hired to do agricultural work? Yes No
- Earned the majority of your income or employment from agricultural work? Yes No
- Moved temporarily in order to do agricultural work? Yes No
- Stopped working in agriculture because of disability or old age? Yes No

US Veteran Status: Have you (patient) completed service in the Uniformed Services of the United State? Yes No

I certify that the above information is true, accurate, and complete to the best of my knowledge. I permit PrimeHealth+ representatives to contact any necessary person or agency to verify this information. I agree to notify PH+ promptly of any changes in household members, address, phone, income, insurance, or other essential information. I understand I must show my card at time of service based on the guidelines established by PrimeHealth+ and/or the State of Colorado. I understand I am responsible for any charges, and I agree to pay my fee/copay at time of service.

The undersigned hereby consents to PrimeHealth+'s use of patient's medical information for those health care operations as defined in the HIPAA privacy regulations (45CFR 164.501) not otherwise permitted under Colorado Law, which shall include uses such as medical review, legal services, auditing functions, business planning development, business management and general administrative activities. PrimeHealth+ is further authorized to disclose patient's medical information to its business associates, such as accountants, attorneys, consultants, and others who perform some of the foregoing health care operations on PH+'s behalf.

_____
Signature of Client/Patient/Guardian/Patient Representative

_____
Print Name

_____
If signed by other than client, indicate relationship

Note: Client representatives shall be required to provide documentation of explanation of authority to act for the client. We will not process any requests signed by a client's representative if authority to act for the client is not clearly described.

FOR STAFF USE ONLY

Fee code: _____ FPL % _____

Eligibility Specialist Signature:

_____

Date: ___/___/___

Financial Statement

INCOME: List ALL household income by GROSS MONTHLY amount:

Source of Income	Yours	Spouse	Dependent(s)
Monthly Gross Wages	**$**	**$**	**$**
Unemployment Compensation	**$**	**$**	**$**
AFDC*	**$**	**$**	**$**
Child Support	**$**	**$**	**$**
Retirement/Pension	**$**	**$**	**$**
Social Security	**$**	**$**	**$**
Rental/Interest Income	**$**	**$**	**$**
Other	**$**	**$**	**$**
TOTAL INCOME: *Not included in total	**$**	**$**	**$**

I certify that the information provided is true and correct to the best of my knowledge. I will report any changes in my situation within one month.

Signature: _____ Date: _____