Keefe Memorial Hospital

PO Box 578
Cheyenne Wells, Colorado 80810
(719) 767-5661

Financial Assistance Program Application

PRIMAY APPLICANT (PARENT IF THE PATIENT IS A MINOR)

Last name_____First_____

DOB_____SS.#_____Phone_____

Physical Address_____

Mailing Address_____

Actively Employed?_____Retired?_____Disabled?_____Unemployed?_____

Employer_____

Are you currently enrolled in Medicaid?_____Medicare?_____

SPOUSES INFROMATION

Last name_____First_____

DOB_____SS.#_____Phone_____

Physical Address_____

Mailing Address_____

Actively Employed?_____Retired?_____Disabled?_____Unemployed?_____

Employer_____

Are you currently enrolled in Medicaid?_____Medicare?_____

DEPENDENT'S INFORMATION

(Please note: only dependents you claimed on your Federal Tax return may be included here)

Last name_____First_____DOB_____SS.#_____

Last name_____First_____DOB_____SS.#_____

Last name_____First_____DOB_____SS.#_____

Last name_____First_____DOB_____SS.#_____

INCOME: List Gross Income for: **APPLICANT** **SPOUSE**

Wages....._____....._____

Farm/Self Employed....._____....._____

Public Assistance....._____....._____

Social Security....._____....._____

Unemployment....._____....._____

Workers Comp....._____....._____

Alimony....._____....._____

Child Support....._____....._____

Military Family Allotments....._____....._____

Pensions....._____....._____

Income: Dividends, Interest, Rent, Etc_____....._____

Other....._____....._____

OTHER INFORMATION

Do you have health insurance?.....Yes____ No____

If yes, what type?_____, Member ID#_____, Group #_____
(Please provide a copy of the front and back of your insurance card(s).)

Have you recently lost your job?.....Yes____ No____

Did you have insurance with your previous employer? .....Yes____ No____

Are you eligible for COBRA benefits? .....Yes____ No____

Have you received financial assistance with KMH before? .....Yes____ No____

If yes, when? _____

Have you ever filed for bankruptcy or do you intend to? .....Yes____ No____

If yes, where? _____ When?_____ Chapter 7____ Chapter 13____

Case Number_____ File date_____ Discharge date_____

Are any of your accounts the results of an accident? .....Yes____ No____

Do you have an attorney involved and/or a settlement pending? .....Yes____ No____

ASSIGNMENT OF RIGHTS

By signing below I certify all the information provided in this financial aid packet is true and accurate. I understand that Keefe Memorial Hospital reserves the right to verify any and all information submitted on this application. Any information found to be incorrect without good reason shall render the application incomplete and ineligible for financial assistance. I further understand that Keefe Memorial Hospital, at its discretion may obtain a copy of my credit report.

All information will remain confidential under the provisions of HIPPA federal regulations, I agree that I will repay the full financial assistance awarded, if I receive payment of any kind for the medical services covered by this application, for example: insurance payments, government program payments, awards from lawsuits or any other payments.

_____ _____

Signature of Applicant **Date**

_____ _____

Signature of Spouse **Date**

_____ _____

State of residence **County of Residence**