Moab Regional Hospital
450 Williams Way · P.O. Box 998
Moab, Utah 84532
(435) 719-3500 · FAX (435) 719-3529
www.mrhmoab.org

FINANCIAL ASSISTANCE PROGRAM CHECKLIST

PATIENT NAME: _____ DATE:_____

If you have difficulty providing these documents, please discuss alternatives with your Financial Navigator.

PROOF OF INCOME:

- ☐ Complete most recent Federal Tax Returns including all schedules
- ☐ If employed: Paycheck stubs for the last 2 pay periods or 2 bank statements
- ☐ If self-employment: Please provide at least one of the following:
  1. IRS Wage and Tax Statement for Self Employed (Form 1099).
  2. Bank statements for 2 months
- ☐ Unemployment, Disability Income, etc. (monthly). Copy of check if disabled/unemployed longer than 6 months
- ☐ Child Support, Alimony (monthly): copy of your divorce decree, legal separation notice or custody agreement

- ☐ Other (as requested by your Financial Navigator): _____

_____

MEDICAL BILLS

- ☐ Copies of all outstanding medical bills from all sources
- ☐ Documentation of any payment plans for medical bills outstanding

MEDICAID APPLICATION

- ☐ Completed Medicaid Application
- ☐ Denial letter from Medicaid

OTHERS: _____

_____

Your Financial Navigator is Connie Beason. Her telephone number is 435-719-3536