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 two pay periods or two bank statements
- ☐ If self-employed: Please provide at least one of the following:
    1. IRS Wage and Tax Statement for Self-Employed (Form 1099).
    2. Bank statements for two months
- ☐ Unemployment, Disability Income, etc. (monthly). Copy of check if disabled/unemployed longer than six months
- ☐ Child Support, Alimony (monthly): copy of your divorce decree, legal separation notice or custody agreement
- ☐ Other (as requested by your Financial Navigator): ____

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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: ____

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Call your Financial Navigator at 435-719-3536.

Revised 03/27/2023

Return Information to:
Mail: Financial Navigator
450 Williams Way
Moab, UT 84532
Phone: 435-719-3536
Email: FinancialAid@mrhmoab.org

FINANCIAL AID APPLICATION

If you need any assistance to complete this form please contact our Financial Navigator, at 435-719-3536. Please review our website (www.mrhmoab.org) for additional information including frequently asked questions, plain language summary, and our Financial Assistance Policy.

INSTRUCTIONS TO COMPLETE THIS FORM:

Please fill out the form completely and returned all required documents to our financial assistance department. Financial assistance will not be awarded to those who do not complete the application process; including the requirement for the patient to apply for other programs for which they may qualify. (e.g. Medicaid).

Please refer to the checklist (separate document) of all required information to be submitted with this application form.

INFORMATION ABOUT YOU

Patient Name		Social Security Number	
Date of Birth	Daytime Phone Number	Other Phone Number	
Person Responsible for Bill	Relationship to Patient	Social Security Number of Responsible Person	
Spouse Name	Spouse Date of Birth	Spouse Social Security Number	
Street Address	City	State	Zip Code
Mailing Address (if Different from Street)	City	State	Zip Code
Length of Time at Above Address	Employer Name	Work Phone Number	

ADDITIONAL HOUSEHOLD MEMBERS

Name	Date of Birth	Relationship

MONTHLY INCOME OF YOUR ENTIRE HOUSEHOLD

If you are unable to provide copies of the verified information; please provide 2 months of bank statements with an explanation on the back of the form.			
Type	Responsible Party Income	Spouse Income	Type of Income Verification Required
Employment Income (Monthly Before Taxes)	$	$	□ Provide paycheck stubs for the last two pay periods or two months bank statements or most recent W-2 form
Self-Employment Income (Monthly Before Taxes)	$	$	□ Provide IRS wage and tax statement for self-employed (Form 1099) or bank statements for two months
Pension, Retirement, Social Security Monthly Income	$	$	□ Provide your Pension/Retirement statement, and/or Social Security award letter
Unemployment, Disability Income, etc. (Monthly) Copy of check if Disabled/Unemployed longer than 6 months	$	$	□ Provide Unemployment, disability award letter, or two months bank statements
Child Support, Alimony (Monthly)	$	$	□ Provide a copy of your divorce decree, legal separation notice or custody agreement
Other (Please list Source):	$	$	□ Provide two months bank statements with an explanation of your income source(s)

ASSETS

Type	Financial Institution(s) Name	Total Balance Amount Now (Approximate as accurately as possible)
Cash		$
Savings Account(s)		$
Checking Account(s)		$
Stocks or Bonds		$

For Medicare Patients Only (as required by Medicare)

401 (k) Balance	IRA Balance

OUTSTANDING MEDICAL BILLS:

Please itemize your outstanding medical expenses and, if known, indicate the amount still owed after the insurance company pays. Attach a separate sheet if necessary.

Name of Provider (Hospital/Physician/Pharmacy)	Your Monthly Payments	Balance Due
	$	$
	$	$
	$	$
	$	$

We ask patients who apply for financial assistance to report other funding. Please check "Yes" or "No".

Question	Yes	No	Details
Does your employer or spouse's employer offer group health insurance?	□ Yes	□ No	If yes, list insurance company here:
Do you have other types of insurance such as Allstate, AFLAC, etc.?	□ Yes	□ No	If yes, list insurance company here:
Do you have a Health Savings/Flex Spending Account	□ Yes	□ No	If yes, what is the available balance:
Does your employer reimburse you for any deductible or healthcare costs?	□ Yes	□ No	Terms of reimbursement:
Were you denied for Medicaid?	□ Yes	□ No	If yes, please attach copy of the Medicaid denial.
Have you applied for state assistance programs (CHIP, PCN, Crime victims, etc.)?	□ Yes	□ No	If yes, which program?
Are you eligible for COBRA through a previous employer?	□ Yes	□ No	If yes, please provide your insurance information here.
Do you have family or church assistance?	□ Yes	□ No	If Yes, please provide detail here.
Is this related to a car accident?	□ Yes	□ No	If Yes, please provide information about the car insurance here.

Please explain any situation to help us understand your inability to pay the medical balance. You may attach a separate sheet if more space is needed. Additional verification may be required.

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Is there any other information you would like us to know to help us make a decision?

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I hereby state that the information given herein is true and correct. I authorize any required verification, including a credit bureau report. I understand that if this information is determined to be false or deceptive, I will be liable for payment of charges for all services rendered. I understand that this request for financial assistance may not pertain to other healthcare providers.

Responsible Party Signature ____ Date _______________________

QUESTIONS? Please call your Financial Navigator at 435-719-3536.

FinancialAid@mrhmoab.org

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