MOAB REGIONAL HOSPITAL

Return Information to:
Mail: Financial Navigator
450 W. 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.

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

Financial Assistance will be based on family size and income only.

INFORMATION ABOUT YOU

Patient Name		Social Security Number (Optional)	
Date of Birth	Daytime Phone Number	Other Phone Number	
Person Responsible for Bill	Relationship to Patient	Social Security Number of Responsible Person (Optional)	
Spouse Name	Spouse Date of Birth	Spouse Social Security Number (Optional)	
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	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 2 months bank statements or most recent W2
Self-Employment Income (Monthly Before Taxes)	$	$	□ Provide IRS wage and tax statement for self-employed (Form 1099) or bank statements for 2 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 2 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 2 months bank statements with an explanation of your income source(s)

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
	$	$
	$	$
	$	$
	$	$

All Questions below are optional for the financial aid program

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

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:
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 that we should be informed of in order to understand your inability to pay the medical balance. You may attach a separate sheet if more space is needed. Additional verification may be required.

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

I hereby state that the information given herein is true and correct. I authorize any required verification, including a credit bureau report. In 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 contact our financial navigation team. 435-719-3536.

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): _____

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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 (Highly Recommended not required)

- ☐ Completed Medicaid Application
- ☐ Denial letter from Medicaid

OTHERS: _____

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Please contact our financial navigation team. 435-719-3500