APPLICATION FOR FINANCIAL ASSISTANCE

UNIVERSITY OF UTAH HEALTH CARE

Patient medical record #: Patient:

Responsible Party: Account Number:

DEMOGRAPHICS

Name _____ Total # of dependent household members _____

Social security #_____ Date of birth _____ Dependents name Date of birth Relationship

Spouse name _____

Social security #_____ Date of birth _____

Address _____

City, State, Zip _____

Phone # _____

INCOME

Verification of all incomes must be attached.

Employer _____ Spouse Employer _____

Employer phone _____ Employer phone _____

Employer address _____ Employer address _____

Monthly net income _____ Monthly net income _____

Other sources of income, e.g. child support, unemployment (source and amount)

_____

If you or your spouse are unemployed, please list on a separate sheet of paper the last date and place of employment. Also list what efforts you are making to gain employment, and attach to this form.

Are you or your spouse self employed _____ If so, please attach a copy of the business balance sheet or list the assets and liabilities on a separate sheet of paper and attach to this form.

ASSETS

Monthly amount paid Name and address

$ _____ Rent or 1st mortgage _____

$ _____ 2nd mortgage _____

Do you own any other real property? _____ If so, please describe _____

_____

VEHICLES

Year _____ Make _____ Model _____ Plate# _____ Monthly balance owed $ _____ Payment $ _____

Name & address of leinholder _____

Year _____ Make _____ Model _____ Plate# _____ Monthly balance owed $ _____ Payment $ _____

Name & address of leinholder _____

Year _____ Make _____ Model _____ Plate# _____ Monthly balance owed $ _____ Payment $ _____

Name & address of leinholder _____

RECREATIONAL VEHICLES (Boats, 4-wheelers, trailers, etc.)

Year _____ Make _____ Model _____ Plate# _____ Monthly balance owed $ _____ Payment $ _____

Name & address of leinholder _____

Year _____ Make _____ Model _____ Plate# _____ Monthly balance owed $ _____ Payment $ _____

Name & address of leinholder _____

Year _____ Make _____ Model _____ Plate# _____ Monthly balance owed $ _____ Payment $ _____

Name & address of leinholder _____

VALUE OF HOUSEHOLD ITEMS

List items and value _____

_____

_____

BANK ACCOUNTS (Savings, checking, certificates, etc.)

Bank and branch	Account number	Balance
_____	_____	$ _____
_____	_____	$ _____
_____	_____	$ _____

RETIREMENT ACCOUNTS (IRA, 401K, etc.)

Bank and branch	Account number	Balance
_____	_____	$ _____
_____	_____	$ _____
_____	_____	$ _____

EXPENSES

	Monthly amount	Past due amount, if any
Food expense	$ _____	$ _____
Utilities		
Power	$ _____	$ _____
Gas	$ _____	$ _____
Home phone	$ _____	$ _____
Cell phone	$ _____	$ _____
Cable or satellite	$ _____	$ _____
Internet provider	$ _____	$ _____
Water	$ _____	$ _____
Clothing		
Cleaning	$ _____	$ _____
Insurance		
Health	$ _____	$ _____
Auto	$ _____	$ _____
Dental	$ _____	$ _____

Homeowner or renters insurance
Is this insurance included in your mortgage or rent payments?
Circle one Yes No Monthly amount $ _____

Day care expense	$ _____	$ _____
Fuel	$ _____	$ _____
Newspaper and subscriptions	$ _____	$ _____
Entertainment	$ _____	$ _____

LIST OF ALL OUTSTANDING MEDICAL DEBT

Name of provider	Address	Original balance	Monthly payments	Present balances
_____	_____	$ _____	$ _____	$ _____
_____	_____	$ _____	$ _____	$ _____
_____	_____	$ _____	$ _____	$ _____
_____	_____	$ _____	$ _____	$ _____

LIST ALL DEBT NOW OWING

Creditor, type of debt (credit card, personal loans)	Monthly payments	Present balances
_____	$ _____	$ _____
_____	$ _____	$ _____
_____	$ _____	$ _____
_____	$ _____	$ _____

PAYMENT AGREEEMENT

I understand that I am responsible to University of Utah Health Care for the health care services that were provided and are outlined in this agreement. According to the terms of this payment agreement, University of Utah Health Care is allowing me to make payments rather than paying the amount I owe all at once. I agree that if I do not pay as required in this agreement, and my account is sent to collection, I must pay all reasonable attorney's fees and collection costs.

Subject to review and approval by the department.

I agree to pay the Billing Office $ _____ per month beginning _____.

I will be able to increase my monthly payments to $ _____ per month beginning _____.

SIGNATURE OF APPLICANT(S)

I hereby certify, and would be willing to state under oath, that the information contained on this form is true and complete to the best of my knowledge. I also understand that a credit bureau report may be pulled to verify resources.

Signature _____ Date _____

Signature _____ Date _____

PLEASE REMIT ALL CORRESPONDENCE TO:

University of Utah Health Care
Billing Office
127 South 500 East, Suite 500
Salt Lake City, Utah 84102-1959

Privacy Act Notice: University of Utah Health Care confidentially maintains your social security number for routine uses, such as facilitating document matching, verifying your identity, tracking your medical history, drug allergies, and preexisting conditions, debt collection, providing this information to payers such as your insurance company, Medicaid, Medicare, or the industrial commission. Disclosure of your social security number is voluntary, but necessary to determine your eligibility for discounts and to extend your credit. If your payer uses your social security number as an identifier, failure to disclose your social security number may result in delay or refusal to pay for covered services, and you may be billed for these services. Your social security number will be used, with your consent for these purposes.

UNIVERSITY OF UTAH
HEALTH CARE