Wray Hospital & Clinic

1017 W 7th Street, Wray, CO 80758 (970) 332-4811

Financial Assistance Application

How to Apply . . .

In order for us to process your application, you must submit ALL of the documents listed below. Any additional documents requested must be received in the Patient Financial Services department within 15 business days. The information received will remain confidential. **The collection process will continue until your financial assistance status is determined.**

Required Documents:

- The completed and signed financial assistance application.
- A complete copy of your signed prior year's federal income tax return.
- A copy of the SSA 1099 form if retired and/or on Social Security.
- If employed, copies of four current, consecutive paycheck stubs for patient and spouse. If Self-employed, a copy of the federal tax form schedule C.
- A copy of the State Assistance program decision notice (Medicaid and CICP) .
- Additional documents / information may be requested after you submit your application.

NOTE: *"Failure to provide information or failure to participate in the interview" is not acceptable and cannot be used in this application.*

Completing the application is not a guarantee you will be approved for the Financial Assistance Program. Approval is based on verified annual household income and family size in accordance with the expanded Federal Poverty Level guidelines established by the Centers for Medicare (CMS).

Once your application has been reviewed, a letter of determination will be sent.

Please feel free to contact us if you need further assistance. You may call us at (970) 332-4811. You can also visit in person at Wray Community District Hospital, Monday through Friday, 8:00 a.m. to 5:00 p.m.

Thank you.

Wray Community District Hospital
Patient Financial Services

Wray Hospital & Clinic

1017 W 7th Street, Wray, CO 80758 (970) 332-4811

Financial Assistance Application

Please fill out all pages completely and print clearly.

Completing the application is not a guarantee you will be approved for financial assistance and our collection process will continue. Additional information / documents may be requested after you submit your application.

Return the signed and dated application to: Wray Community District Hospital 1017 West 7th Street Wray, CO 80758

Patient Information

Facility: ____ Account Number(s): ___________________________________

Patient Name: ___________________________________ Social Security #: ______________________________________

Address: _______________________________________ City: __________________ State: ________ Zip: _____________

Home Phone number: _________________________ Contact Phone number: _______________________

Assistance Requested By: _______________________________ Relationship to Patient: ___________________

Spouse Information

Guarantor Name: ________________________________ Social Security #: ______________________________________

Address: ______________________________________ City: ___________________ State: ________ Zip: _____________

Home Phone number: _________________________ Contact Phone number: __________________________

Household Information

Please list all household members including yourself:

Name	Relationship	Age	Dependent
			Yes No
			Yes No
			Yes No
			Yes No
			Yes No
			Yes No
			Yes No

Employment Information

Employer: ________________________ Address: _____________________________________

Telephone: _______________________ Position: _____________________________________

Years at Job: ______________________ Pay dates: __________________________________

Salary: __________________________

Spouse Employment Information

Employer: ________________________ Address: _____________________________________

Telephone: _______________________ Position: _____________________________________

Years at Job: ______________________ Pay dates: __________________________________

Salary: __________________________

Housing

Do you rent or own your home? ☐ Rent ☐ Own Monthly Rental or Mortgage Payment **$**__________

If own, what is the value of your home: **$**___________ Mortgage Balance **$**___________

Finances

Cash on hand: **$**__________________ Total in Checking/Savings account: **$**______________________

Bank Name	Type of Account	Bank City & State	Balance

Do you have any other forms of income (child support, alimony, structed settlement payments)?

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Vehicles and Other Asssets

Please list the make, model, year of each car/truck/equipment you own.

Make	Model	Year	Monthly PMT	Value	Owing

Expenses

Total Monthly Expenses: **$**__________________

Expense	Monthly Payment	Amount Past Due	Present Balance
Auto			
Mortgage / Rent			
Utilities			
Television			
Telephone / Cell Phone			
Auto & Home Insurance			
Child support / Alimony			
Groceries / Toiletries			
Health (Hospital, clinic, etc)			
Pharmacy			
Credit Card Payment			
Loan Payment			
Other (list):			
Other (list):			
Other (list):			

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Return the signed and dated application to:

Wray Community District Hospital
1017 W 7th Street
Wray, CO 80758

I hereby request that Wray Community District Hospital consider my request for financial assistance. I understand all disclosed income information is for the sole purpose of determining my eligibility for financial assistance and will be kept confidential.

Should I become eligible to receive any third-party funding I am obligated to report this and my financial assistance eligibility may be reversed.

All of the information which I have provided to Wray Community District Hospital Billing Office for myself and on behalf of my family is true and correct to the best of my knowledge. I further understand that if any of the information is found to be false, my financial assistance application may be denied.

Print name: ____________________________________

Signature: _____________________________________ Date: ___________________

Additional Patient Comments

Comments: ____

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