



SCL Health  
500 Eldorado Blvd. Bldg. 6 Suite 6300  
Broomfield, CO 80021-3408

Thank you for choosing SCL Health for your healthcare needs. Sisters of Charity of Leavenworth Health System is proud to provide quality and affordable healthcare for the community. We are here to assist those who are in need of financial assistance and to help those who may have questions or need guidance making health care choices for themselves and their families.

SCL Health has a program to help patients who need financial assistance with paying all or part of their bills. To apply for this program, please fill out the information on the attached financial assistance application.

In order to process your application, we also require supporting documentation. A list of required documents can be found on page four (4). This information must be received within 15 days from the date of this letter if received in person. If you feel that you need to explain your situation further in order to obtain financial assistance, additional space has been provided at the end of the application.

It is important that applications be filled out completely and returned with required documents. Failure to do so will slow down processing the application and possibly be reason for denial. Applications received without a signature will be denied.

If for any reason the above information cannot be obtained, please call the Revenue Service Center at 303-813-5400 or 1-866-665-2636 between the hours of 8 a.m. and 4:30 p.m. We will be more than happy to assist you.

Once a decision has been made regarding your account, you will be notified by a mail with the results of our decision.

Sincerely,

Financial Coordinator  
SCL Health

**Health Care Financial Assistance Application**

**General Information**

Patient Name \_\_\_\_\_ Account # \_\_\_\_\_

Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ County \_\_\_\_\_

Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_

Email \_\_\_\_\_

Single  Married/Significant Other  Divorced/Separated  Widow/Widower

Responsible Party Name \_\_\_\_\_ Relationship \_\_\_\_\_

Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_

Name(s) and age(s) of dependents living with you for whom you are responsible. Please include DOB:

_____	_____
_____	_____
_____	_____

**Financial Assistance Application**

**INCOME**

Prior year's **AGI** (Adjusted Gross Income) reported to the IRS (found on Form 1040) \_\_\_\_\_  
 If you did not file a tax return, please explain \_\_\_\_\_

Current Employer \_\_\_\_\_

Address \_\_\_\_\_

Phone Number \_\_\_\_\_ Occupation \_\_\_\_\_

Length of Employment \_\_\_\_\_ years \_\_\_\_\_ months Full Time / Part Time \_\_\_\_\_  
 Number of hours scheduled to work each week \_\_\_\_\_

If unemployed, date of unemployment: \_\_\_\_\_ Are you receiving unemployment Yes / No \_\_\_\_\_  
 If YES – Beginning date \_\_\_\_\_ Amount receiving weekly \_\_\_\_\_

Spouse / Significant Other's Current Employer \_\_\_\_\_

Address \_\_\_\_\_

Phone Number \_\_\_\_\_ Occupation \_\_\_\_\_

Length of Employment \_\_\_\_\_ years \_\_\_\_\_ months Full Time / Part Time \_\_\_\_\_  
 Number of hours scheduled to work each week \_\_\_\_\_

If unemployed, date of unemployment: \_\_\_\_\_ Are you receiving unemployment Yes / No \_\_\_\_\_  
 If YES – Beginning date \_\_\_\_\_ Amount receiving weekly \_\_\_\_\_

Income on a Monthly Basis	Yours	Spouse	Assets	Value/Balance
Gross Pay			Current Home	
Alimony/ Child Support			Other Property (land, investment, rental, etc.)	
Social Security			Vehicle(s)	
Unemployment / Work Comp			Investments - Stocks, Bonds, Mutual Funds, 401k, IRA, Annuities	
Retirement / Pension			Savings Account 1.	
Interest / Rental			Savings Account 2.	
Public Assistance			Checking Account	
Other			Other	
Monthly Total			Other	

**(Office use only) Annual Total** \_\_\_\_\_

**EXPENSES**

Name of Mortgage Holder or Landlord \_\_\_\_\_

Address \_\_\_\_\_

	Monthly Payment	Outstanding Balance	Current Yes / No
Mortgage / Rent			
Home Owner's /Renter's Insurance			
HOA			
Telephone - home			
Cell Phone			
Electricity			
Gas			
Water			
Cable / Satellite / Dish			
Auto Loan			
Auto Loan			
Auto Insurance			
Transportation - Gas			
Life Insurance			
Health Insurance			
Medical Bills			
Prescriptions			
Food			
Child Care			
School Expenses / Loans			
Alimony / Child Support			
Credit Card Bills			
Internet			
Other			
Other			
<b>Monthly Total</b>			

(Office use only) Annual Total \_\_\_\_\_

**OTHER**

Do you receive food stamps?            Yes            No

Do you have medical benefits?        Yes            No

If no, have you applied for Medicaid? \_\_\_\_\_ Date Applied \_\_\_\_\_

If benefits were denied, what reason was given? \_\_\_\_\_

\_\_\_\_\_  
Date Medicaid was denied \_\_\_\_\_

**REQUIRED DOCUMENTS:**

- **Completed, signed and dated application**
- **Copy of your last 3 months of pay stubs for you, spouse and/or significant other**
- **3 months bank statements (includes personal/savings/business accounts, displaying account owner's name and account number**
- **Copy of award letter(s) – Unemployment, Social Security, etc. displaying monthly benefit**
- **Child Support / Court Ordered Maintenance**
- **Copy of prior year's tax returns (all pages) must be submitted with this application. Cannot accept W2 forms.**
- **If unemployed and / or living with friend or family, page three (3) "Expenses" must be filled out**

**If unemployed and living with family or friend**

Page three (3) of the financial application must be completed showing what the monthly mortgage/rent, electric/gas and cable statements reflect. (Please do not provide receipts)

**If Applicant of Spouse is self-employed:**

Must provide copy of the business ledger for the last three (3) months

**Non-US Residency**

Provide a copy of your photo ID. Passport, Visa, etc.

**We will deny applications that are incomplete.**

**Your signature is required to complete this application.**

My signature attests that the information I have provided on this form is accurate and true to the best of my knowledge. I understand that SCL Health System requires verification of income before any determination is made. I also understand that my credit may be accessed, at no expense to me, to verify the above information.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Please use space below if needed:

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Office Use Only:

Family Size\_\_\_\_\_ Income\_\_\_\_\_ Yearly Expenses\_\_\_\_\_ Poverty Level\_\_\_\_\_

Out Pt. Responsibility\_\_\_\_\_ In Pt. Responsibility \_\_\_\_\_ Clinic Responsibility\_\_\_\_\_ Level:\_\_\_\_\_

Special Notes: \_\_\_\_\_

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Financial Coordinator Name: \_\_\_\_\_  
Decision Date \_\_\_\_\_

Approved

Denied