Summit Healthcare ASSOCIATION

SUMMIT HEALTHCARE FINANCIAL ASSISTANCE APPLICATION

This form collects information that is not part of the medical record.-PLEASE PRINT CLEARLY

PATIENT NAME: _____ VISIT ID: _____

INSTRUCTIONS: Complete application and attach copies of:

- Tax return and supporting schedules (last two years)
- Pay stubs (most recent three months)
- Social Security Benefits (if applicable)
- AHCCCS determination letter
- Bank statements (most recent three months, all accounts)
- W-2 or unemployment statements
- On a separate page, describe your need for financial assistance

ALL DOCUMENTATION MUST BE SUBMITTED WITH COMPLETED APPLICATION FORM NO LATER THAN: _____DATE

[ ] YES [ ] NO I have applied for Federal or State medical assistance- AHCCCS and I have attached a copy of my determination letter. If No-explain reason for no determination letter: _____

_____

[ ] YES [ ] NO I have a lawsuit, settlement, personal injury or liability claim pending.

If yes- Date of accident/injury _____ CLAIM NUMBER _____

Explain your situation _____

Legal Representative handling your case: Name_____ Phone _____

Address_____

[ ] YES [ ] NO I have the availability of Insurance coverage through my employer **or** [ ] YES [ ] NO my spouse's employer.

Explain your situation_____

PATIENT/RESPONSIBLE PARTY

_____ _____ _____
Name (first, middle, last) Social Security number Birth Date (MM/DD/YYYY)

_____
Mailing Address/City/State/Zip code

_____
Physical Address-City/State/Zip code

_____ MARITAL STATUS [}S [ ]M [ ]D [ ]W [ ]OTHER _____
Phone Household Size (Patient/Spouse/Dependents)

_____ Employment Status [ ] Fulltime [ ] Part time [ ] Self Employed [ ] Unemployed [ ] Student
Alternate Phone

_____ _____ _____
EMPLOYER NAME Start Date Unemployed Start Date (MM/DD/YYYY)

SPOUSE/PARTNER

_____ _____ _____
Name (first, middle, last) Social Security number Birth Date (MM/DD/YYYY)

_____ Employment Status [ ] Fulltime [ ] Part time [ ] Self Employed [ ] Unemployed [ ] Student
Phone

_____ _____ _____
EMPLOYER NAME Start Date Unemployed Date/Length (MM/DD/YYYY)

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HOUSEHOLD MEMBERS-Please list all individuals-include children under age 18 and any fulltime college students.
TOTAL IN HOUSEHOLD_____ (If more than five dependents use a separate page to list)

Full name	DOB (MM/DD/YYYY)	Relationship	Gross Monthly Income	Employer
1.	___/___/____			
2.	___/___/____			
3.	___/___/____			
4.	___/___/____			
5.	___/___/____			

BANK and Investment ACCOUNT(S) List all accounts/use another page if needed

Bank Name:	IDENTIFY TYPE OF ACCOUNT: (CHECKING/SAVINGS/INVESTMENTS/SECURITIES)

PROPERTY-provide address or the year-make-model

Type	Details	Estimated Value	Unpaid Balance
Primary Residence			
2nd Residence/Vacation Home			
Land/include number of Acres			
Rental Property			
Business/Farm Equipment			
Recreational Vehicle			
Car/Truck/Van/SUV			
Other			

PROVIDE DOCUMENTATION FOR ANY OF THE FOLLOWING SOURCES OF INCOME

Income Description/Source	MONTHLY Income Amount
Current Employment	
Interest/Dividends	
Pension/Retirement	
Rental Property	
Disability	
Alimony/Child Support	
Other	

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PATIENT NAME: _____ VISIT ID: _____

INSURANCE POLICY- Include Type of Plan (HEALTH – LIFE - LONG TERM CARE) **Include name of Company policy is with**	**Monthly Payment**

MEDICAL DEBT

List type- H=Hospital D=Doctor OP=other provider O=other facility

Type	**Owed To**	**Remaining Balance**	**Monthly Payment**

CERTIFICATION:

I certify that all the information listed is true and correct to the best of my knowledge. I understand that the information provided is to be used to determine my ability to pay for services provided by Summit Healthcare and possibly qualify for any financial assistance program available from Summit. This may include some reduction to the patient balances owed for services rendered.
I hereby grant permission to Summit Healthcare, representatives or its agents to investigate the information contained herein, and to obtain credit reports necessary to review my application.
I understand that by reviewing the provided information, Summit Healthcare will use the Federal Poverty guidelines to determine my eligibility for any financial assistance or charitable adjustment to my patient balance.

PATIENT/RESPONSIBLE PARTY **DATE (MM/DD/YYYY)**

_____ _____

Signature

_____

Print name

SPOUSE/PARTNER **DATE (MM/DD/YYYY)**

_____ _____

Signature

_____

Print name

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PATIENT NAME: _____ VISIT ID: _____

THIS SECTION WILL BE COMPLETED BY THE FINANCIAL COUNSELOR

Initial Interview _____ **Date:** _____

Application taken by: _____ **Date received:** _____

Contents reviewed: _____ **Date:** _____

PROOF OF INCOME-DOCUMENT CHECK LIST COMPLETED/ATTACHED TO APPLICATION [ ] YES

TOTAL GROSS ANNUAL HOUSEHOLD INCOME AS REPORTED ON APPLICATION: $_____

OUTSTANDING MEDICAL EXPENSES $_____

REMAINING INCOME AFTER MEDICAL EXPENSES $_____

TOTAL $_____/FPL _____= %_____EQUATES TO _____% ADJUSTMENT

DESCISION ON ELIGIBILITY [ ] YES [ ] NO REASON APPLICATION DENIED_____

_____ **DATE** _____

Patient/Applicant Notified of Decision [ ] YES Date/Time _____ **by:** _____

Method of Notification: [ ] Phone call/spoke direct to Patient [ ] Phone call/spoke to Representative Name:

_____

[ ] Written Notice of Decision mailed to Patient/Representative Date: _____ **by:** _____

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THIS SECTION WILL BE COMPLETED BY THE FINANCIAL COUNSELOR

SUMMIT HEALTHCARE FINANCIAL ASSISTANCE PROGRAM APPLICATION-DOCUMENTS REQUIRED CHECKLIST:

PATIENT NAME: _____ **VISIT ID:** _____

Y N N/A

[ ] [ ] [ ] **Completed Signed FAP Application**

[ ] [ ] [ ] **Picture Identification provided by [ ] AZ Driver License [ ] Passport [ ] Other** _____

[ ] [ ] [ ] **AHCCCS Acceptance/Denial Letter**

[ ] [ ] [ ] **Tax Returns-Complete with supporting schedules for past 2 years. State/Federal**

[ ] [ ] [ ] **W-2 form or 1099 if Self Employed/Contract Employee**

[ ] [ ] [ ] **Pay Stubs- last 3 months**

[ ] [ ] [ ] **Unemployment Statement**

[ ] [ ] [ ] **Bank Statements-all accounts for past 3 months**

[ ] [ ] [ ] **Social Security Benefit Letter**

[ ] [ ] [ ] **Financial Need Letter from Patient/Representative**

[ ] [ ] [ ] **Credit Report from** _____ **Agency obtained on date** _____

[ ] [ ] [ ] **Visit ID Charge Summary**

[ ] [ ] [ ] **Bankruptcy Notice/Filing paperwork Case#** _____**date filed**_____

[ ] [ ] [ ] **Lien/Injury Claim on file-Date of injury** _____**Attorney/Representative contact information**

Name _____

Address _____

Phone _____

[ ] [ ] [ ] **Health Insurance cards/insurance coverage verification documents**
Insurance coverage through_____**ID**_____

GROUP# _____

Benefit Summary_____

[ ] [ ] [ ] **Other**_____