Uintah Basin Healthcare

Mail to: Uintah Basin Healthcare
250 West 300 North
Roosevelt, Utah 84066
Fax to: 435.722.6104

Financial Assistance Application

If you need help to complete this form please ask to speak with our Patient Financial Counseling Department at 435.725.2060.

Instructions for completing this form:

Please fill this form out completely and return all required documentation to a Financial Counselor. Patients may not receive financial assistance if they do not complete the entire application process, or if they could have qualified for programs such as Medicaid, but chose not to apply.

Please submit the following documentation:

1. **Copies of your current Federal Tax Return with all schedules, including W-2s.**
2. **Family income verification (paycheck stubs) for the last two pay periods.**

Patient's Full Name: **Birth Date:**

Responsible Party

Full Name SS# Birth Date

Relationship to Patient Employer Name

Address City State U Zip

Home Phone Cell Phone Work Phone

How long have you lived at this address? Years Months

If less than 12 months, please list previous addresses for the last 12 months:

Address	City	State	Zip	From (Month/Year)	To (Month/Year)

Spouse Name Spouse SS# Spouse Date of Birth

Spouse Home Phone Spouse Cell Spouse Work #

Spouse Employer Name

Additional Household Members

Name	Birthdate	Relationship

Name	Birthdate	Relationship

Please continue this application on the following page.

Family Monthly Income

Type	Amount
Employment Income (Gross)	$
Employment Income for Spouse (Gross)	$
Pension / Retirement, Unemployment, Disability Income, etc.	$
Child Support	$
Grants/Scholarships	$
Alimony	$
Other *(Please list sources)*:	$

We ask patients who apply for financial assistance to look for other funding in addition to UBH Financial Assistance. Please check "Yes" or "No" for each of the following:

Does your employer or spouse's employer offer group health insurance? ☐ Yes ☐ No If yes, list insurance company:

Do you have other types of insurance such as Allstate, AFLAC, etc.? ☐ Yes ☐ No If yes, list insurance company:

Do you have a Health Savings / Flex Savings Account? ☐ Yes ☐ No If yes, list balance:

Does your employer reimburse you for any deductible? ☐ Yes ☐ No

Were you denied for Medicaid? Please attach a copy of the Medicaid denial. ☐ Yes ☐ No

Have you applied for state assistance programs (CHIP, PCN, Crime Victims, etc.)? ☐ Yes ☐ No

Are you eligible for COBRA through a previous employer? ☐ Yes ☐ No

Do you have family or church assistance? ☐ Yes ☐ No

☐ ***I hereby state that the information given herein is true and correct. I authorize any required verification, including a credit bureau report. I 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 health care providers.***

Responsible Party Signature **Date**

Checklist of all required information to complete application process:

- ☐ Front and back of form filled out completely.
- ☐ Copies of your current federal tax return with all schedules, including W-2s.
- ☐ Form signed and dated.
- ☐ Family income verification (paycheck stubs) for the last two pay periods.

Print Save