Mt. Grant General Hospital 200 S. A St., P.O. Box 1510, Hawthorne, NV 89415 (775) 945-2461

FINANCIAL ASSISTANCE APPLICATION

How to Apply...

In order to process your application, ALL required documents must be submitted. Any additional documents requested after original submission must be received in the Collections Department within 15 days. This information will remain confidential. The collection process will remain in effect until your financial status is determined for all currently open accounts. PLEASE make your scheduled payments accordingly or make other arrangements by calling 775-945-2461 ext. 249. The application does not affect any accounts which may have been submitted to a collection agency.

REQUIRED DOCUMENTS...

- Completed financial assistance application
- Proof of household income: (provide only those which apply to your needed)
  - If employed, copies of two months (current) consecutive paycheck stubs or documentation from human resources department which contains this information
  - If self-employed, copies of your current tax return, including schedule C
  - If applicable, (retired/disabled/social security/etc) copies of 1099 forms from previous and current year. (1099 updates will be required each year) * * *
  - If on unemployment, copy of award letter and most recent check (EFT statement)
- If ZERO income, please call for additional information
- Copies of two most recent bank statements; checking and savings accounts (not registers)
- Copies of any outstanding medical bills (doctors, ambulance, etc)
- Copy of denials from Medicaid (must have for all minor children, uninsured household members)
- Copy of all billing /expenses as listed on the application

* **contact the IRS / Social Security by calling 1-800-772-1213 if you do not have copies***

Completing the application is not a guarantee you will be approved for the Financial Assistance Program at Mt Grant General Hospital. Approval is based on annual household income and family size in accordance with the expanded Federal Poverty Guidelines established by the Centers for Medicare and Medicaid (CMS) specifically for the state of Colorado, Arizona, Wyoming, Nebraska, Nevada and California. All uninsured household members must submit proof of denial from Medicaid applications.

You will be sent a notification letter after your financial assistance status is determined.

Should you have any questions or require any further information please call (775) 945-2461 ext 266, to schedule an appointment; Monday - Friday 07:00 a.m. - 2:00 p.m. - leave a message if no answer.

05/17/21 jdr

FORM SSA-1099 – SOCIAL SECURITY BENEFIT STATEMENT

2015 • PART OF YOUR SOCIAL SECURITY BENEFITS SHOWN IN BOX 5 MAY BE TAXABLE INCOME.
• SEE THE REVERSE FOR MORE INFORMATION.

Box 1. Name		Box 2. Beneficiary's Social Security Number
Box 3. Benefits Paid in 2015	Box 4. Benefits Repaid to SSA in 2015	Box 5. Net Benefits for 2015 *(Box 3 minus Box 4)*

DESCRIPTION OF AMOUNT IN BOX 3

DESCRIPTION OF AMOUNT IN BOX 4

Box 6. Voluntary Federal Income Tax Withheld

Box 7. Address

Box 8. Claim Number *(Use this number if you need to contact SSA.)*

Form **SSA-1099-SM** (1-2016) **DO NOT RETURN THIS FORM TO SSA OR IRS**

For HOSPITAL USE ONLY: do not write here *Expires one year from approval date*

GUARANTOR ID# :	Gross Monthly Income: $	ADMINISTRATOR approved: Yes / No
Number in household:	*MGGH Balance:* $	Approved disc: 0 25% 50% 75% 100% Administrator Initial / date:

Mailing Address PO Box 1510 Hawthorne, NV 89415	**MT GRANT GENERAL HOSPITAL** **APPLICATION for FINANCIAL ASSISTANCE** **APPLICATION/UPDATE/CHANGE FORM** **775-945-2461**	Street Address 200 South A Street Hawthorne, NV 89415

This form may be duplicated. Print legibly or type information requested on the form in its entirety. If any of the information on this form changes, submit a revised form to the department. *Attach additional page(s) as necessary*.

Legal Name of Applicant:		**Phone:**
Please list any aliases/previous names:		Cell :
Date of Birth: **Age:**		
Current Address:	**(**street**)**	**PO Box**:
(city**)**	(state)	(zip code)
Marital Status (circle one): Single Married Divorced Separated Widow(er)	**Social Security Number:**	**Driver's License # / State:**

Reason for submission of forms (circle one): New Applicant Name change Employment Status Address Change Additional Family Member Update requested

Please list all persons living within the Applicant's household : ** use additional sheets as needed **	**Date of birth:** *** Include SELF ***	**SSN:**	**Do they have a source of income and amount (if employed, hours per week worked)attach proof of income**			
			Yes	No	$	
			Yes	No	$	
			Yes	No	$	
			Yes	No	$	

Applicant/Guarantor Employer Name:	Address:	Phone:
Position / Length of Employment:		Salary / Hours Worked per Week: $
*** Spouse / "Significant Other" Employer Name:**	Address:	Phone:
Position / Length of Employment:		Salary / Hours Worked per Week: $

***For the purposes of this application spouse may refer to "significant other or any other person residing in the household ***
PROOF OF INCOME IS REQUIRED: (CURRENT W2/PAY STUBS, RECENT TAXES FILED, 1099 FORMS* AND TWO BANK STATEMENTS)
Applications not including this information will be delayed; those not responding to requests will be destroyed after 15 business days.

***For participants: must include previous, current and pending years (if applicable – near end of year.) MUST BE SUBMITTED/UPDATED ANNUALLY**

Revised 03/28/2017

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Nearest friend or relative NOT LIVING in your household	Name:	Relationship:
Address:		Phone number:

Insurance Information: ** use additional sheets as needed **	**Is anyone in household eligible or receiving:**	**Medicare: (circle) YES NO**	**Medicaid: (circle) YES NO**

INSURED'S NAME:	**Name of Insurance/Name of policy holder**	**Insurance ID #**	Please circle one:
			Primary Secondary
			Primary Secondary
			Primary Secondary
			Primary Secondary
			Primary Secondary

Unearned Income:

Source:	Receiving:		Applied for:		**For who:**	Claim number:	Amount per month:
FOOD STAMPS	Yes	No	Yes	No			$
WIC	Yes	No	Yes	No			$
MEDICAL WELFARE MEDICAID	Yes	No	Yes	No			$
CHILD SUPPORT	Yes	No	Yes	No			$
ALIMONY	Yes	No	Yes	No			$
UNEMPLOYMENT	Yes	No	Yes	No			$
SOCIAL SECURITY	Yes	No	Yes	No			$
SUPPLEMENTAL SSI	Yes	No	Yes	No			$
VETERAN'S BENEFITS	Yes	No	Yes	No			$
DISABILITY	Yes	No	Yes	No			$
RETIREMENT	Yes	No	Yes	No			$
ANY OTHER INCOME (TYPE)	Yes	No	Yes	No			$

Resources:

Type:	(circle)		Name of Financial Organization:	Account VERIFIED -MONTH	Balance:
Checking Account	Yes	No			
Savings Account	Yes	No			
Credit Union Share	Yes	No			
Trust Account	Yes	No			
Savings Bonds	Yes	No			
Stocks/Bonds	Yes	No			

*****Applicants with NO income source MUST also include a letter from the party who is providing living expenses *****

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Type:	Monthly Cost:	Type:	Monthly Cost:
Water/Garbage/Sewage	$_____	**Electric Power**	$_____

Telephone	$_____	**Cell Phone**	$_____
Gas/Propane	$_____	**Cable TV/Satellite**	$_____
Rent/Mortgage Payment	$_____	**Groceries (estimated)**	$_____
Property tax if no mortgage	$_____	**Other** $_____	**Other** $_____

	CREDIT / CHARGE CARD:	
Company Name	Balance Owing	Monthly Payment
	$	
	$	
	$	
	Outstanding Loans:	
Financial Institution	Balance Owing	Monthly Payment
	$	$
	$	$
	$	$
	$	$

Are there any loans secured by collateral? (circle):	Yes**	No
**** If YES, by what collateral:**	_____	

Please attach copies of all bills as listed in application
other than Mt Grant General Hospital or Mt Grant Medical Clinic

List health care providers *other than Mt Grant General Hospital / Clinic:*	City and State:	Balance Owed:
		$
		$
		$

I authorize Mt Grant General Hospital to verify all information given on this application including but not limited to bank account information and credit references. The information provided is true to the best of my knowledge and any false information will be grounds for denial or termination. I agree to make all co-payments at time of service. (Relief will not be applied until payment is made) Must be updated annually.

_____ _____
Applicant Signature **Date**

For hospital use only – SCAN AT TERM OR UPDATE	**Date received:**	**Received By:**	**Completed Application:**
	Additional Information:	**Notice Mail Date:**	
	STATUS LETTER SENT: YES NO	**1 YR RENEWAL SENT: YES NO**	**RENEWAL RCVD: YES NO**

Revised 03/28/20177 *Potential updates every 6 months or when notified changes occur*