



Care Support Program

The Telluride Medical Center provides quality health care to all residents of the Telluride Hospital District, regardless of their ability to pay.

Application Instructions:

1. Determine if you live or work in the Telluride Hospital District.
If not, consider our other options: Care Credit or Payment Plan.
2. Complete and sign the application on the reverse of this sheet.
3. Submit the required documentation within 3 days of visit.

Required Documentation:

I. Proof of Residence or Employment in THD (choose ONE):

- TWO Pay stubs from a local employer OR
- Rental agreement OR
- Signed letter from a landlord, w/contact number OR
- Utility bill OR
- Other official document with physical address listed

II. Proof of Income:

Working Applicant-

- Most recent federal income tax forms OR
 - Most recent W2 forms OR
 - Most recent 2 pay stubs (or combination of stubs that reflect you average yearly income) OR
 - Signed letter from employer verifying income
- PLUS**
- Statement of additional income from tips, bonuses, child support, etc.

Non-Working Applicant-

- Documentation of sources of assistance or support
(letters from family, lenders, other assistance programs, etc.)
- Bank statements from last 3 months, credit card statements, trust, savings and investment account statements

Over →

Care Support Application

For office use only:

ACCEPTED DENIED

_____ % DISCOUNT

Start Date: ____/____/____

Applicant Information:

Name: _____ Date of Birth ____/____/____

Home Phone: _____ Cell: _____

Mailing Address: _____

Physical Address: _____

Employer: _____ Phone: _____

Employer II: _____ Phone: _____

Monthly Income (gross): _____ Annual Income (gross): _____

If seasonal: High Avg: _____ (# months/yr) ___ Low Avg. _____ (# months/yr) ___

Other financial support *: _____

You MUST include cash tips, bonuses, alimony, child support, government assistance, and any other income/assistance from any source.

Other income earning family members:

1. Name: _____ Relation: _____

Employer/s: _____ Phone: _____

Monthly Income: _____ Annual Income: _____

Dependants:

Number of family members, including yourself, being supported: _____

Name: _____ DOB: ____/____/____ Relation: _____

Name: _____ DOB: ____/____/____ Relation: _____

Name: _____ DOB: ____/____/____ Relation: _____

Name: _____ DOB: ____/____/____ Relation: _____

Name: _____ DOB: ____/____/____ Relation: _____

Who, if anyone, in the family is insured?: _____

Affidavit:

"I _____ attest under penalty of perjury that the
aforementioned information is complete and correct.

Signature: _____ Date: _____

Person accepting application _____

Documents Provided: 1. _____ 2. _____ 3. _____

Notes: _____

- Scan Appl.
- Pt Notes
- FH Record #
- Updated Spreadsheet
- Card
- Letter
- Billing Adjustments
- Removed from collections
- Removed from AR Services
- Complete