TELLURIDE
REGIONAL MEDICAL CENTER

FOR OFFICE USE ONLY:
☐ ACCEPTED ☐ DENIED
_____% DISCOUNT
START DATE:____/____/____

CARE SUPPORT APPLICATION

APPLICATION DEADLINE: 1 MONTH Please add information on another page if needed.

APPLICANT(S) INFORMATION: (please print)

NAME: _____ DATE OF BIRTH: ____/____/____

PHONE: _____ CELL: _____

MAILING ADDRESS: _____

OTHER INCOME EARNING FAMILY MEMBER(S) IN HOUSEHOLD:

Please include proof of income for this person(s) also.

NAME: _____ RELATION: _____
PHONE: _____ CELL: _____ EMPLOYER: _____

NAME: _____ RELATION: _____
PHONE: _____ CELL: _____ EMPLOYER: _____

EMPLOYER(S): _____

Please attach all financial documents from ALL working in the household.

(Attach one check stub showing your year to date income, unemployment income, cash pay income needs to be reported with a letter from your employer, child support, tips, any other forms of income or assistance not listed.)

If your work is seasonal, what months are:

HIGH SEASON: How many months of the year are high season? _____

LOW SEASON: How many months of the year are low season? _____
Approximate # of hours per week during low season: _____

Please list the start month/year of employment for each Job(s): _____
_____ _____ _____

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

NAME: _____ DOB: ____/____/_____ RELATION: _____
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PLEASE SIGN AND DATE:

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

SIGNATURE: _____ DATE: _____