

**FINANCIAL ASSISTANCE APPLICATION**

**APPLICANT INFORMATION:** (print, please)

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_

Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many months per year do you work? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a bank account? YES  NO 

Tax return? YES  NO 

**DEPENDENTS: All persons in your household who don’t work.**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_Relation: \_\_\_\_\_\_\_\_\_\_\_

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_/\_\_\_/\_\_\_ Relation:\_\_\_\_\_\_\_\_\_\_\_ Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_/\_\_\_/\_\_\_ Relation:\_\_\_\_\_\_\_\_\_\_\_ Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_/\_\_\_/\_\_\_ Relation:\_\_\_\_\_\_\_\_\_\_\_ Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_/\_\_\_/\_\_\_ Relation:\_\_\_\_\_\_\_\_\_\_\_

**OTHER INCOME EARNING FAMILY MEMBER IN HOUSEHOLD:**

**Please, include proof of income for these people as well.**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation: \_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation: \_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation: \_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **“I attest under penalty of perjury that the aforementioned information is complete and correct.”**

 **SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_ /\_\_\_\_\_ /\_\_\_\_\_**

**PO Box 1229** - **500 W Pacific Ave, Telluride, CO 81435** - [**www.tellmed.org**](http://www.tellmed.org/)- **(970) 728-3848** - **Fax: (970) 728-3404**



**FINANCIAL ASSISTANCE APPLICATION INSTRUCTIONS**

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

 If you have any questions, or need help in completing this application, please call or text Cali al 970.708.8745.

**INSTRUCTIONS:**

1. Complete,sign and attach all required documents.
2. You can also mail the application and required documents to:

 *Telluride Medical Center P.O. Box 1229 Telluride, CO 81435*

or fax 970-728-3404.

**REQUIRED DOCUMENTS:**

Medicaid letter of denial AND at least two of the three items listed below:

1. Previous year's tax return.
2. Last three months’ paystubs or income verification.
3. Last three months’ bank statements from all bank accounts.

 **\***If you work for cash, you’ll need to sign an Affidavit with your income information.

**Non-Working Applicant:**

 1. Documentation of sources of assistance or support (letters from family, lenders, other assistance programs, etc.).

1. Bank statements from last 3 months, credit card statements, trust, savings and investment account statements.
2. Medical Assistance Determination (proof of Medicaid denial).

***MEDICAID* APPLICATION NFORMATION**

(Qualification is based on income and family size)

 **ONLINE**: [www.colorado.gov/hcpf](http://www.colorado.gov/hcpf)

 or

 **CALL TRI-COUNTY at** 970.708.7096



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