COLORADO CENTER FOR PAIN & WELLNESS

Financial Assistance Application

ACKNOWLEDGEMENT

Applicant Name				
Street	**City**	**State**	**ZIP**	**Phone**

ACCEPTANCE OF FINANCIAL ASSISTANCE:

☐ YES I request to be considered for Financial Assistance. I will complete the Application Form.

☐ NO I choose not to apply for Financial Assistance at this time. I am waiving my right to any financial assistance for which I may otherwise be entitled. I understand that I will be responsible for full payment of all charges at the time of service. I may apply at any time in the future if my financial situation changes.

BASIS OF APPLICATION:

☐ SLIDING FEE DISCOUNT PROGRAM *(complete pages 2-4 and 6, skip page 5)*

☐ CHARITY CARE DISCOUNT PROGRAM *(complete pages 5 and 6, skip pages 1-4)*

Patient Name (Please Print)	**Signature of Patient or Guarantor**	**Date**

Please submit your completed application to the front desk of any of our clinic locations. You will be notified of the determination for your financial assistance, or, if applicable, the reason for denial.

SLIDING FEE DISCOUNT PROGRAM

HOUSEHOLD MEMBERS

Based on the definitions in the table below, please enter the number of household members for each category.

Relationship	Include	Do Not Include	Number
Applicant			1
Spouse	Include if you are legally married, regardless of sex. Include if you are legally married but living apart (for example, spouse is away on military duty, away on work, or away for some reason other than legally separated or divorced).	Do not include if you are legally separated or divorced. You do not need to claim your spouse if you are a victim of domestic abuse, domestic violence, or spousal abandonment.	
Child(ren)	Include number of tax dependent children. Include adopted and foster children, living with you that you can claim as a tax dependent. Include the number of children with whom you share custody if you can claim them as a tax dependent.	Do not include if a child is a non-dependent. Do not include if a child is unborn.	
Other Dependents	Include the number of parents you claim as tax dependents. Include the number of siblings and others who you claim as dependents.	Do not include unmarried domestic partner unless you have a child together or you will claim them as a tax dependent. Do not include roommates.	
		Total	

Please list all eligible household members below:

Individual	Name	Date of Birth
Applicant		
Other:		
Other:		
Other:		
Other:		
Other:		
Other:		
Other:		

I certify that the household members listed above are accurate and true.

Patient Name (Please Print)	**Signature of Patient or Guarantor**	**Date**

SLIDING FEE DISCOUNT PROGRAM

INCOME

Please enter the incomes for all household member(s) for each category given in the table below.

Source of Income	Applicant Income	Other Household Members Income	Total Annual Income
Gross Wages, salaries, tips, etc. (before tax)			
Income from business and self-employment (before tax)			
Unemployment Compensation, worker's compensation, social security, supplemental security income, veteran's payments, survivor benefits, pension, or retirement income.			
Interest, dividends, royalties, income from rental properties, estates, and trusts, alimony, child support, assistance from outside the household, and other miscellaneous sources.			
		Total	

Proof of income is required for ALL members of your household. The documents listed below are acceptable proof of income. Please check all that apply and include copies of each with your application.

- ☐ Latest Income Tax Return (Form 1040)
- ☐ Most Recent W2 Form
- ☐ Most Recent Form 1099
- ☐ Two Recent Pay Stubs (must be back-to-back paystubs dated within 30 days of the application)
- ☐ Employment Verification Letter (including income and company letterhead)
- ☐ Social Security Award Letter (current year letter with monthly income noted for each person)
- ☐ Unemployment Benefit Letter or Statement (available through the local Job Service office)
- ☐ Bank Statements (showing direct deposits)
- ☐ Child Support and/or Alimony
- ☐ Pension or Retirement Income
- ☐ Disability or Workers' Compensation Determination Letter
- ☐ Veteran's or Survivor Benefits
- ☐ Notarized letter of support from a third party
- ☐ Income Self-Declaration (see page 4 – only applicable if income is not reported in the above list)

I certify that the household income listed above is accurate and true.

Patient Name (Please Print)	**Signature of Patient or Guarantor**	**Date**

SLIDING FEE DISCOUNT PROGRAM

INCOME SELF-DECLARATION

Please complete this form only if other proof of income is not available.

Applicant Name:				
Street:	**City:**	**State:**	**ZIP:**	**Phone:**

Reason for Self-Declaration:

☐ I am currently homeless or unstably housed
☐ I am paid in cash and do not receive pay stubs
☐ I recently lost my job
☐ Other: _____

Who is supporting you financially?

Name: **Phone:**

Street: **City:** **State:** **ZIP:**

Nature of Support: ☐ Pays for Rent ☐ Pays for Food ☐ Pays for Utilities ☐ Pays Cash for Work

Estimated Income:

Notes:

Consent and Acknowledgement:

By my signature below, I certify that the information provided above is accurate and true to the best of my knowledge. I understand that this information may be subject to random audits for verification, which may involve contacting the individual providing financial support.

Patient Name (Please Print)	**Signature of Patient or Guarantor**	**Date**

CHARITY CARE DISCOUNT PROGRAM

EXTRAORDINARY CIRCUMSTANCES

For patients that have experienced recent hardship that impacts their income and ability to pay for healthcare services, Charity Care Discounts shall be considered at the sole discretion of the COCPW Financial Assistance Committee. These circumstances may include but are not limited to recent:

- ☐ Loss of Employment
- ☐ Death in Family
- ☐ Physical Disability
- ☐ Mental Illness
- ☐ Recent Financial Hardship

Please provide a brief description of your extraordinary circumstance:

I certify that the reason(s) for requesting financial assistance for extraordinary circumstances are accurate and true..

Patient Name (Please Print)	**Signature of Patient or Guarantor**	**Date**

DECLARATIONS

I certify that:

	Initials
1. The information provided above is true and accurate to the best of my knowledge.	
2. I agree to promptly update my application if my financial situation changes.	
3. I understand that I must apply for Financial Assistance on an annual basis (every 12 months) to maintain eligibility.	
4. I understand that I will be charged the full cost of services rendered until my application for financial assistance is approved.	
5. I understand that if I do not qualify for financial assistance, I will be responsible for all charges not covered by my insurer or payer of benefits.	
6. I understand that if I qualify for Financial Assistance: a. the approved discount will apply to eligible COCPW fees. b. I am responsible for all balances owing after the appliable discount is applied in accordance with the COCPW Patient Payment Policy, COCPW-FRM-305D. c. The resulting discount may be applied retroactively for up to 3 months prior to the date of application. A credit will be given if the patient has overpaid and has no overdue balances owing to COCPW.	
7. I understand that financial assistance provided under this program is conditioned upon the continued cooperation of me and/or my guarantor in the clinic's pursuit of fair reimbursement from my insurer or payer of benefits. Failure to cooperate with such pursuits shall result in forfeiture of financial assistance.	
8. I understand that payments are due on the date of service, and it is my responsibility to contact the clinic if I am unable to make the required payments to discuss options.	
9. I acknowledge that intentionally providing false information may result in the termination of my eligibility for Financial Assistance, in which case I will be responsible for paying the full, usual, and customary charges.	

Patient Name (Please Print)	Signature of Patient or Guarantor	Date

Please submit your completed application to the front desk of any of our clinic locations. You will be notified of the determination for your financial assistance, or, if applicable, the reason for denial.

OFFICE USE ONLY

Patient Name:	
Patient DOB:	
Date of Application:	
Financial Assistance	☐ Sliding Fee Discount Program ☐ Charity Care Discount Program
Approved Discount:	☐ 100% ☐ 75% ☐ 50% ☐ 25% ☐ 0% Reason for Denial: _____
Effective Date:	
Patient Added to Discount Log: (COCPW-FRM-303)	☐ YES
Patient Notified:	☐ YES
Approved By (Name):	
Approved By (Signature):	
Date Approved:	
Application Renewal Due Date:	
Notes:	