PIONEERS
MEDICAL CENTER

FINANCIAL ASSISTANCE PROGRAM

Eligibility Requirements:

- Coverage is provided for all family members living at home, including students up to the age of 21. Children for whom child support is provided will be counted as a household member.
- You are required to fully and accurately disclose all sources of family support and income at the time you apply for assistance. Failure to do so can terminate your assistance if approved.
- You must meet income guidelines.
- Services which are covered by auto, casualty, or 3rd party liability insurance are not eligible under this program.
- **This is *not* an insurance program**. Please pay your portion of the bill **when you receive services**. If you do not pay your portion of the bill, you could be subject to be charged for the full amount of the services provided.
- It is the policy of Pioneers Medical Center/Meeker Family Health Center to provide **essential** services regardless of the patient's ability to pay. The following procedures are **excluded** from the Financial Assistance Program:
  - Pre-scheduled elective surgeries that are not medically necessary.
  - Procedures denied by insurance are not eligible for financial assistance.
  - Aesthetic Procedures/Cosmetic surgery.
  - Nursing home care.
- Eligibility for discounts is based on income and family size only. No other factors are used to assess eligibility.
- Eligibility will be reviewed annually or if your financial situation changes.

Cost:

- Applicants will be given a rating based on their total household income and family size; copayment percentages will be determined as a result of the rating. Applicants are eligible to receive care at the time of application.
- Outstanding balances will be adjusted for services provided 30 days prior to the signed application and all copays will be due at the time of the completion and approval of the application.
- Balances not paid within 120 days will be transferred to A-1 Collection Agency.

Required Documentation:

Applicants are required to provide the following documents:

Identification (If married, both spouses.)

_____ Copy of valid driver's license or photo ID

_____Social Security Numbers, dates of birth and full names of all members of household

Employment or Other Income (If married, for both spouses)

____Copy of prior year's federal income tax returns

____Copy of most recent 3 months of pay stubs, OR copy of unemployment benefits letter, social security income, or pension income.

____Self-employment income

_____Rental income amount (If applicable)

____ Any other kind of income you receive. Refer to Financial Assistance Policy for additional sources of income.

FINANCIAL ASSISTANCE PROGRAM APPLICATION

Name:_____
Address:_____
City:_____**State:**_____**Zip:**_____
Home Phone: (___)_____**-**_____
Cell Phone: (____)_____**-**_____

Applicant date of birth: _____
Applicant Social Security number: _____**-**_____**-**_____

Household members (include those for whom you provide child support.)
_____**DOB**_____
_____**DOB**_____
_____**DOB**_____
_____**DOB**_____
_____**DOB**_____
_____

Notes: _____
_____

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NOTE: ***THIS IS NOT AN INSURANCE PROGRAM. IT APPLIES ONLY TO PIONEERS MEDICAL CENTER AND MEEKER FAMILY HEALTH CENTER*** **. It does not apply to:**

1. *Other Medical Facilities*
2. *Pharmacies*
3. *Professional fee for specialty providers even if they provide services at Pioneers Medical Center/Meeker Family Health Center. You will have to make arrangements with that doctor for payment of their professional services.*
4. *Pathology services (St. Mary's, Valley View Hospital, etc)*
5. *Radiology services provided by Mountain Radiology*
6. *Durable Medical Equipment provided by DJO Global.*

I understand that by providing this information to Pioneers Medical Center that my eligibility will be verified and determined for services rendered by Pioneers Medical Center and Meeker Family Health Center (including Colorado Advanced Orthopedics). Should the information I provide be false, a denial in eligibility may result and I will be liable for payment in full.

I affirm the completed information, and that which I provide, is true and correct to the best of my knowledge. If I am eligible for the Financial Assistance Program and fail to make the required payments, I am aware the balances of my account and those family accounts listed on this application will be sent to a collection agency.

_____

APPLICANT'S SIGNATURE DATE

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For Eligibility Technician Use ONLY: Please mark the boxes that indicates which documents were verified for eligibility and keep a photocopy of such documents presented in the applicant's file.

ANNUAL INCOME: (both spouses: employment, unearned, self-employment) $_____

NUMBER OF HOUSEHOLD MEMBERS: _____

RATING: _____

COPAY: _____

Financial Counselor Signature: _____Date: _____