

Financial Assistance Program Application Instructions

Guarantor Account: _____

Date: _____

Dear Guarantor:

Attached is an application for the Financial Assistance Program offered by Renown Health. This program is for individuals who feel they may need assistance in fulfilling their financial obligation for medical services.

Requirements:

The purpose of the Financial Assistance Program is to provide assistance to guarantors who do not qualify for Federal, State, or County assistance and have no reasonable means to pay their liability. If you have not already applied directly to these agencies, you may contact for a Guarantor Financial Assistance Specialist for assistance in applying by calling 775-982-4110.

- ✓ All items on the application must be completed in full.
- ✓ A co-payment of \$_____ to be determined based on prescreen is required at the time you submit your application. Payment will be applied to any outstanding balances regardless of application approval.
- ✓ Proof of Income and Expenses (attach copies):
 - Prior Year Filed **Tax Forms** (1040 forms and corresponding schedules)
 - Last 4 months of Pay Stubs and/or other **Source of Income** (social security, unemployment, child support, alimony, etc.)
 - Last 4 months of **Bank Statements** (include linked accounts; all pages)
 - Last 4 months of **Mortgage or Rent** Receipts
 - Last 4 months of statements from any **Other Asset Accounts** (i.e. Retirement funds (401k, 403b, 503b, IRA, etc.) insurance policies, investments, life insurance distribution, legal settlement funds, etc.)
- ✓ You must have proof of application and denial for assistance through your county's Social Services and State Welfare programs.
- ✓ A Trans Union Credit Report will be run to verify all information as presented on the application for Financial Assistance funds.

After all supporting documentation has been submitted, you will be notified in writing or by phone of the final determination of your eligibility. Please update us if your address or phone numbers changes.

If you have any questions regarding the Financial Assistance Program, please contact a Financial Assistance Specialist at Renown Health by calling 775-982-5747.

Renown Health
850 Harvard Way T-6
Attn: Medical Financial Hardship
Reno NV 89502

Financial Assistance Program Application PATIENT INFORMATION

IMPORTANT: Please read and complete the entire form before signing.
The information you provide must be accurate for proper processing.

Pt. Account No:

Date of Birth:

Date of Application:

NAME OF PATIENT		DATE OF ADMISSION			
NAME OF RESPONSIBLE PARTY (Guarantor)		SOCIAL SECURITY NUMBER		HOME PHONE NUMBER	
ADDRESS		RELATIONSHIP TO PATIENT		HOW MANY PEOPLE RESIDE IN HOUSEHOLD	
EMPLOYER		EMPLOYER ADDRESS		EMPLOYER PHONE	
HOW LONG THIS EMPLOYMENT		OCCUPATION			
SPOUSE'S NAME		SOCIAL SECURITY NUMBER	OCCUPATION	HOW LONG THIS EMPLOYMENT	
SPOUSE'S EMPLOYER		EMPLOYER'S ADDRESS		EMPLOYER'S PHONE NUMBER	
NAME OF CLOSEST RELATIVE			RELATIONSHIP		
ADDRESS			PHONE NUMBER		
GUARANTOR INFORMATION:					
1. REAL PROPERTY :		ADDRESS:			
2. CASH ON HAND:					
3. BANK/CREDIT UNIONS/TRUST REFERENCES AND ACCOUNTS:					
NAME	ADDRESS	TYPE & ACCT NUMBER	BALANCE		
4. INSURANCE POLICIES:					
NAME	TYPE & POLICY NUMBER		VALUE		
5. STOCKS/BONDS:					
DESCRIPTION			VALUE		
6. BUSINESS OWNERSHIP:					
NAME & ADDRESS		TYPE OF INTEREST HELD		VALUE	
7. VEHICLES:					
DESCRIPTION			VALUE		
8. DEEDS OF TRUST, NOTES:					
9. MISCELLANEOUS:					
10. ARE YOU ELIGIBLE FOR COUNTY OR STATE WELFARE? IF SO, DESCRIBE BASIS OF ELIGIBILITY				<input type="checkbox"/> YES	<input type="checkbox"/> No

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT. I ALSO AUTHORIZE RENOWN HEALTH TO OBTAIN INFORMATION NECESSARY FOR VERIFICATION OF MY FINANCIAL POSITION.

SIGNATURE OF RESPONSIBLE PARTY

Date