Financial Assistance Application

Please Attach:

Last Four (4) weeks of Family Income (Check Stubs, Copies of Checks, Unemployment Verification, etc)
Previous Years Federal Tax Filing. If you did not file taxes please call the IRS at 800-829-0922
and request a statement that shows they have no record of you filing income tax.

Patient Name	**Age**	**Phone No.**	**Marital Status**	**Patient Social Security No.**
			S M W D	

Patient	**Person Responsible for Bill**	**Relationship**
Address	Name	
City, State, Zip	Address	
	City, State Zip	
Date of Birth	Social Security Number	
Phone ( )	Phone ( )	

Employment	
Patient's Employer	Person Responsible Employer
Occupation	Occupation
If Unemployed, Name Last Employer	If Unemployed, Name Last Employer
How Long Unemployed	How Long Unemployed

List Below All Members of Household (Exclude Patient)		
Name	Age	Relationship to Patient

Do you have health insurance coverage available?	Yes	No	**Have you applied for Medicaid?**	Yes	No

If yes, why not available for this date of service?	**Date Applied:**
If no, please indicate reason for lack of insurance coverage:	**If denied, date:**

Insurance cost is too high	**Pre-Existing Condition**	**Other, Please Describe (e.g. employer does not provide insurance)**	**Reason for denial:**
Y | N	Y | N		**Please attach copy of Medicaid denial letter, if denied**

Complete Other Side of Application • Do Not Write Below This Line

Approved ____________________ Reviewer ____________________
Level of Approval

Date ____________________

Denied Missing Info [ ] Exceeds Income [ ] Other____________________

Taos Health Systems

1397 Weimer Road
Taos, NM 87571
575-751-5786

Monthly Income • Attach Copies of Proof of Income for the Last Four (4) Weeks			
	Patient	Spouse	Other
Wages			
Social Security			
Pensions			
Unemployment/Workers Comp			
Alimony/Child Support			
Government Assistance			
Food Stamps			
Disability Payments			
Rent/Royalty			
Scholarship/Grants			
Dividends/Interest			
Other, List			
Annual Family Household Income		**Attach Previous Years Federal Tax Filing**	

Expenses	**Monthly**	**Balance Due**	**Assets**	Value
Mortgage or Rent Payment			Savings	
Vehicle Payment			Checking	
Child Care			Money Market	
Medical Expenses			CD's	
Credit Cards			Investments, Stocks, Bonds	
Household Expenses (Utilities/Food)			Home (Market Value)	
Other, List			Cars/Motorcycles	
			Other, List	

Other Pertinent Information Regarding Financial Situation

Disclaimer
I CERTIFY THAT THE INFORMATION PROVIDED IN CONNECTION WITH THIS FINANCIAL ASSISTANCE APPLICATION IS CORRECT AND COMPLETE. I AUTHORIZE VERIFICATION OF ANY INFORMATION AND I UNDERSTAND THAT ADDITIONAL DOCUMENTATION MAY BE REQUESTED. I ALSO AUTHORIZE THE HOSPITAL TO SHARE THIS FORM AND ATTACHMENTS, AND THE DETAILS OF THE FINANCIAL ASSISTANCE PROVIDED, WITH TAOS HEALTH SYSTEMS. I UNDERSTAND THAT IF ANY INFORMATION IS FOUND TO BE FALSE, THE FINANCIAL ARRANGEMENT OR ASSISTANCE MAY BE VOIDED.

Patient/Responsible Party Signature	**Date**