Boulder Community Health

FINANCIAL ASSISTANCE APPLICATION

Thank you for your interest in the Colorado Indigent Care Program/Boulder Community Health Wecare Program. In order to process your application, we will need copies of the following information within **90 days** of your date of service. Please submit information as soon as possible.

1. Copy of Driver's License or state ID card. If married, include spouse ID.

2. If employed, provide copy of last month's paycheck stubs or a letter from employer stating gross income earned for last month. 2, 2 weeks stubs or 4, 1 week stubs. If married, must include spouse income.

3. If self employed you may use bank statements, a profit and loss sheet, ledgers, logs, invoices, receipts, etc., to show your income. You may use a separate sheet for business expenses. Please call for more information, 303-415-4718. Tax Returns may NOT be used. Information must be current.

4. Provide proof of Social Security income, if applicable, either SSI or SSDI.

5. Include proof of any other income, this may include but is not limited to: Payments from pension plans, unemployment, child support, alimony, rental income, money from friends/family, etc.

6. If you have no income from any source please include a letter explaining your current situation.

7. Copy of all bank accounts and investment accounts for last month.

8. Please fill out and sign page 2 of this application.

You **MUST** provide all information listed above that pertains to you. A hardship letter may be included to explain your situation. If this information is not returned with the application, it will be considered incomplete and returned to you. You may call to set up an appointment for the Financial Assistance Screen, 303-415-4718 OR:

Please mail completed application and info to:

BCH
Attn: Financial Assistance
PO BOX 9049
Boulder, CO 80301-9049

OR

Drop off application and info:

BCH
Patient Financial Services
5450 Western Ave
Boulder, CO 80301

Please call 303-415-4718 with any questions or for additional information.

Patient Name: _____

Responsible Party info:

Name: _____ DOB_____ SSN_____
Address: _____Phone#: _____
Employer: _____Length of employment: _____

Spouse info:

Name: _____ DOB_____SSN_____
Employer: _____Length of Employment: _____

Dependents listed on Tax Form:

Name: _____ DOB: _____ SSN: _____
Name:_____ DOB:_____ SSN:_____
Name:_____ DOB:_____ SSN:_____
Name:_____ DOB:_____ SSN:_____

Assets:

Please include last month bank statement (checking, savings, money market) and any investment accounts.

Vehicle (s) 1. year,make_____ current value_____ loan balance _____

2. year,make_____ current value_____ loan balance _____

Do you own property or land other than your current place of residence: Y/N
If yes, please explain.

I hereby certify that to the best of my knowledge and belief, the information listed on this statement and the information I have provided is true and complete.

Applicant signature: _____ Date: _____