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. Please submit the 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. If you need to provide more than one month for a good average you may do so.

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. Information must be current. Please start with last month and turn in as many months as needed to show a good average. At least 3 months preferred.

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 account statements and investment account statements for last month. If you have extra deposits in your bank account, please explain them or they will be counted as income.

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 drop off or mail completed application, along with all documentation to:

BCH Patient Service Center
Attn: Financial Assistance
5450 Western Ave
Boulder, CO 80301

Please call 303-415-4718 with any questions. You may also email info to **patientservicecenter@bch.org**

Patient Name: _____

** If Patient is over 18 but a full time student and being claimed on parent (S) income tax, this screening will go off of parent (S) income/assets with patient being listed as a dependent.

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, cd's) and any investment accounts. Pay Pal accounts are also needed, please include.

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: _____

Updated: 1/2021