

Thank you for your interest in being screened for Financial Assistance at Boulder Community Health. If you choose to apply for an official financial assistance determination, depending on the date of service, we will screen you for the Qualified Charity Care Program (QCCP) and Colorado's Hospital Discounted Care (HDC). This screening also reviews possible eligibility for Health First Colorado Medicaid, Emergency Medicaid, CHP+, Medicare and Connect for Health Colorado.

If we end up determining you are not eligible for QCCP and/or HDC but appear eligible for our in-house financial assistance program, WeCare, we will request additional documentation (liquid asset documentation for last month).

For more information on financial assistance, please view our Financial Assistance Policy at <https://www.bch.org/patient-visitors/patient-services/financial-assistance>.

In order to screen you for assistance, please fill out and submit the following information as soon as possible.

Patient's last name:	
Patient's first name:	
Patient's middle initial (optional):	
Patient's street address:	
Patient's city of residence:	
Patient's zip code:	
Patient's county:	
Patient's primary phone number:	
Patient's primary email address:	
Patient's preferred method of contact (mail or email):	
Is the patient experiencing homelessness? Y/N	
Patient's date of birth:	
Is the patient a resident of or currently living in Colorado? Y/N	
Is the patient currently pregnant? Y/N (People who are pregnant sometimes qualify for some additional programs)	
Is anyone in the patient's household under the age of 19? Y/N	
Does the patient have a disability? Y/N	
Does the patient receive federal disability income? (People who receive	

federal disability income can automatically qualify for Medicare) Y/N	
Does the patient have health insurance? Y/N	
Has the patient ever been covered by Medicaid or CHP+? Y/N	
If so, does the patient know their ID number? If so, provide the ID number.	
Does the patient have an unexpired Qualified Charity Care Program rating? If so, provide the rating.	
How many people live in the patient's household, including the patient? (The patient is required to include their spouse/civil union partner - if applicable)	
Does the patient have any income? If so, about how much money do they receive each month before taxes?	
Is anyone in the household currently pregnant? Y/N	
If so, how many babies are expected? (Some programs take pregnancy into account when counting how many people are in the household)	

*****Please answer the following questions depending on the number of household members and add members if there are more than 7*****

Household Member 2	
Name:	
What is their relationship to patient?	
Does this household member have any income? If so, about how much money do they receive each month before taxes?	
Is this household member included in the patient's taxes? Y/N	
Household Member 3	
Name:	
What is their relationship to patient?	
Does this household member have any income? If so, about how much money	

do they receive each month before taxes?	
Is this household member included in the patient's taxes? Y/N	
Household Member 4	
Name:	
What is their relationship to patient?	
Does this household member have any income? If so, about how much money do they receive each month before taxes?	
Is this household member included in the patient's taxes? Y/N	
Household Member 5	
Name:	
What is their relationship to patient?	
Does this household member have any income? If so, about how much money do they receive each month before taxes?	
Is this household member included in the patient's taxes? Y/N	
Household Member 6	
Name:	
What is their relationship to patient?	
Does this household member have any income? If so, about how much money do they receive each month before taxes?	
Is this household member included in the patient's taxes? Y/N	
Household Member 7	
Name:	
What is their relationship to patient?	
Does this household member have any income? If so, about how much money do they receive each month before taxes?	
Is this household member included in the patient's taxes? Y/N	

Please return the information above within 14 days by:

Email it to: financialassistance@bch.org

Or via mail to:

Patient Service Center
ATTN: Financial Assistance
Boulder Community Health
PO Box 9049
Boulder, CO 80301

A financial assistance representative will contact you within 45 days after receiving the above information. Please contact us with any questions through MyBCH Customer Service messages or by one of the following:

Email: financialassistance@bch.org

Phone: 303-415-4718

Please refer to our financial assistance policy at <https://www.bch.org/patient-visitors/patient-services/financial-assistance> for more information.

***Note:** If you currently have an active payment plan, that plan will now be terminated due to state requirements. This allows time for the financial assistance process to complete. Once completed, we will work with you to establish an updated payment plan, if necessary.

Thank you,
BCH Financial Assistance

Boulder Community Health (BCH) provides language assistance services, including electronic and written translated documents and oral interpretation, free of charge and in a timely manner. BCH provides reasonable modifications for individuals with disabilities, and appropriate auxiliary aids and services, including qualified interpreters for individuals with disabilities and information in alternate formats, such as braille or large print, free of charge and in a timely manner to ensure accessibility and an equal opportunity to participate to individuals with disabilities. For more information, visit www.bch.org/patient-visitors/patient-services/compliance/notice-of-non-discrimination.