Financial Assistance Program Application Instructions

Renown Health
850 Harvard Way
Mail Stop T6
Reno, NV 89502

P 775.982.5747
F 775.982.3220
www.renown.org

Guarantor Account: _____

Date: _____

Dear Applicant:

Thank you for allowing us to be of assistance to you. Attached is an application for the Financial Assistance Program offered by Renown Health.

The purpose of the Financial Assistance Program is to provide financial relief to guarantors who do not qualify for Federal, State, or County assistance, and have no reasonable means to meet their financial obligations for necessary medical services. The documents requested are used solely to determine eligibility for the Financial Assistance Program.

If you have not already applied directly for Federal, State or County assistance we can help you with a simple screening to determine your potential eligibility. Please contact our Financial Assistance Specialist for help in applying by calling 775-982-4110.

Financial Assistance Requirements:

- ✓ 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 (attach copies):
  - Recent month of Pay Stubs and/or other **Source of Income** (social security, unemployment, child support, alimony, etc.)
  - Last month's **Bank Statements** (include linked accounts, all pages)
  - Last month's/quarter's statement from any **Other Asset Accounts** (i.e., Retirement funds (401k, 403b, 503b, IRA, etc.) insurance policies, investments, life insurance distribution, legal settlement funds, etc.)
  - Prior Year Filed **Tax Forms** (1040 forms and corresponding schedules)
- ✓ You must have proof of application and denial for assistance through your county's Social Services and State Welfare programs or of being excess income to apply
- ✓ A Trans Union Credit Report will be run to verify all information as presented on the application for Financial Assistance funds

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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 change.

If you have any questions regarding the Financial Assistance Program or need help completing the application form, 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
YEARS/MONTHS EMPLOYED	OCCUPATION		
SPOUSE'S NAME	SOCIAL SECURITY NUMBER	OCCUPATION	YEARS/MONTHS EMPLOYED
SPOUSE'S EMPLOYER	EMPLOYER'S ADDRESS		EMPLOYER'S 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 □ YES □ 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.

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SIGNATURE OF RESPONSIBLE PARTY Date