the memorial hospital at craig

750 Hospital Loop
Craig, CO 81625
970-824-9411

Date:
Date of Service:

Application for Sliding Fee

Upon approval, discounts will be applied to the services rendered at The Memorial Hospital.

Name: _____ SS# _____

Address: _____ Telephone# _____

_____ DOB: _____

☐ Please check here if you have recently experienced a job loss

Total Number Living in the Home* _____ ***ALL** people living in the home are to be listed - **even if not related or not working.** Use reverse side of form if necessary.

Name (First & Last)	**Relationship**	**DOB**	**Monthly Income**	**Health Insurance**?(Medicaid,Aetna etc.)

*** Members listed will be cross-checked with our records. Applications with discrepancies will be returned for additional information.**

List all **HOUSEHOLD** income and **ATTACH VERIFICATION** for **EVERY** person who lives in the home**.

Please attach **copies** of the following documents:

1. Must report most recent years' tax return.
2. If application if after July 1st, must also report pay stubs from the 3 most recent pay periods.
3. Social Security / Pension Benefit or Award Letter.
4. Bank Statements (or bank letter) showing direct deposits.
5. Interest Statements.
6. Divorce/Custody decrees stating payment to be made.
7. Foster Care/Adoption subsidy agreements.

**** Applications for discounted services will be returned if all proof of income is not attached.**
***** TMH Business Office will review your application and notify you within two weeks.**
*****Must reapply for each Medical Situation.**

I request that The Memorial Hospital (TMH) make a determination of my eligibility for the sliding scale for services rendered by the hospital (does not include physician clinics). I understand that the information I submit is subject to verification by TMH. I also understand that if the information which I submit is determined to be false, such a determination will result in denial of the sliding scale eligibility, and I will be liable for payment in full.

I affirm that the above and attached information is true and correct to the best of my knowledge. If I become eligible for the sliding scale and do not make the required payments, I am aware that my account, and/or the accounts of my eligible family members listed above, will be sent to a collection agency.

APPLICANT SIGNATURE: _____ DATE: _____

TMH Representative Signature_____ Discount %_____DATE_____

Updated 03/21/12