MIND SPRINGS *health* Prevention. Care. Recovery. WEST SPRINGS *hospital* Psychiatric Care & Recovery

Financial Assistance Application (FAA)

Instruction: Complete entire application, provide proof of income, sign and date

Client Demographics		
Client Name	Date of Birth	SSN#
Address	City, State Zip	Phone Number

Please circle all responses

Are you a U.S. Citizen? **Yes** **No** Are you a documented immigrant? **Yes** **No**
Are you a resident of the State of Colorado? **Yes** **No** **If yes, must provide copy of CO ID**
Are you claimed as a dependent on anyone's taxes? **Yes** **No** Who claims you as a dependent? _____

*Provide copy of insurance card(s)
Do you have health insurance? **Yes** **No** Insurance name & ID:_____
Do you have Medicare? **Yes** **No** Medicare ID#_____
Do you have Medicaid? **Yes** **No** Medicaid ID#_____
Have you applied for Medicaid? **Yes** **No** Date applied for Medicaid? _____

Are you currently incarcerated? **Yes** **No** How long have you been incarcerated?_____

Marital Status: Single/NeverMarried Married Legally Separated Divorced Widowed

Household Income: Include any person that receives 50% of financial support from household

	List all household members	**Relationship**	**Date of Birth**	**Employer/Source**	**Gross Income**
1		**Self**			
2		**Spouse**			
3		**Dependent**			
4		**Dependent**			
5		**Dependent**			
	Annual household gross income				**$**

_____I am currently unemployed and do not qualify for unemployment benefits.
_____I have no source of income at this time.**
_____I am homeless and/or lack permanent night time residence.**
**If marked, complete Homeless/Zero Income Attestation

Should you have any questions, a financial counselor is available to assist you
Monday – Friday from 8:00AM to 4PM toll free 1(888)320-5218

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Must include applicable items from this proof of income verification list (Exhibit B)

Income Type	Supporting Documentation	MSH Use Only
Wages/Tips/Salary	Paystubs	
Unemployment Compensation	Award letter or statement	
Self Employment Income	Prior year income tax return or YTD Profit/Loss statement	
Worker's Compensation	Award or Determination of Benefits letter	
SSI or SSDI	Benefit letter, Statement of benefits received, notice of award	
Alimony	Court decree	
Rental Income	Copy of lease	
Trust Fund	Letter from trustee	

Inpatient ONLY

____I approve WSH to contact my employer to obtain my income verification, complete ROI form

____I do NOT approve WSH to contact my employer for income verification

Additional information:

I hereby certify that the information listed herein is correct to the best of my knowledge and give Mind Springs Health/West Springs Hospital permission to verify any information listed. I understand that if I do not provide proof of income, the application is incomplete, and I will be expected to pay the balance that has been deemed my responsibility, in full.

Client/Patient or authorized representative signature _____

Print Name _____ Date _____

MSH/WSH Staff only
Client ID#
Staff _____Date _____

POI verified? Yes No FPL_____%
Eligibility: Approved Denied
Type: OBH Internal