



GRAND COUNTY EMERGENCY MEDICAL SERVICES APPLICATION FOR FINANCIAL ASSISTANCE

Dear Patient:

Grand County Emergency Medical Service (“EMS”) is proud of its mission to provide quality care to all who need it, 24 hours a day, seven days a week, 365 days a year.

Grand County EMS is dedicated to providing medically necessary health care services; these services are accessible to all, regardless of age, gender, geographic location, cultural background, physical mobility, or ability to pay.

Grand County Government acknowledges that in some cases the patient will not be financially able to pay for the services received. In these cases the patient will be asked to complete this application for financial aid assistance.

It is important that you let us know if you will have trouble paying your bill; federal and state laws require all EMS Departments to seek full payment of what they bill patients. This means we may turn unpaid bills over to a collections agency, which could affect your credit status.

Financial Assistance is offered for the following:

Self Pay Patient- An individual who does not have third party coverage by a commercial third-party insurer, or any other Federal Healthcare Program coverage for all or any part of their bill.

Under-insured Patient- those that have third party coverage or third party liability which after full payment of liability leaves a balance greater than 30% of billed charges on the account. Benefits that are applied to the patient deductible or co-pay is considered payment by the insurance company and not considered as part of the 30% balance.

Medicaid/ CICP (Colorado Indigent Care Program)- Patients who receive services prior to the effective date will be considered for Financial Assistance.

If you have any questions regarding the Financial Assistance Application, please contact Robin at the GCEMS Administrative Division Office at 970-887-2732. We will treat your question(s) with confidentiality and courtesy.

Account # _____

Patient Information:

Full Legal Name _____
Social Security Number _____ - _____ - _____
Date of Birth ____/____/____ Age _____ Sex M F
Physical Address _____

Mailing Address _____

Home Phone _____ Work Phone _____ Other _____
Employer _____

Responsible Party / Legal Guardian Information

Full Legal Name _____
Relationship _____ Phone Number _____
Social Security Number _____ - _____ - _____ Date of Birth ____/____/____
Physical Address _____

Mailing Address _____

Employer _____ Work Phone Number _____

Household Information

Number of incomes _____
Total household income _____ (monthly)

FAMILY SIZE- Family living in your household

First Name	Last Name	Age	Relationship

Income Information

List combine income for yourself, spouse and other household members

	Total- Last 3 Mo.		Total- Last 12 Mo.
Wages			
Self employment Earnings			
Public Assistance			
Social Security			
Unemployment			
Alimony			
Child Support			
Income From Dividends			
Resources (Bank Acct, Investments, Loans, etc.)			
Total:			

To further assist us in processing your application for financial aid, please provide copies of the documents indicated below which apply to your particular situation.

- IRS forms: W-2 or 1099
- Tax Return: U.S. Federal form 1040 or Country of Citizenship
- Last 3 Payroll Statements or Unemployment Benefits Statements (evidence of start date)
- Social Security Award letter
- Mortgage Payment/Rent Receipt and/or Letter from whomever pays the rent or mortgage
- Most Recent Bank and/or Brokerage Statements
- Any Medicaid and/or Health Benefits Acceptance or Denial Letter
- Any Document that relates to information provided on the application's signature page, for example: Food Stamps, Public Assistance, Self Employment
- **If you are a student, please provide documentation of your student status**

Documents listed above are necessary to determine your eligibility, if you are unable to provide Grand County EMS with any of the above documentation or information, please include an explanation as to why they cannot be provided. These must be approved by the EMS Chief and Administrative Captain on a case by case basis.

Account # _____

A note describing your situation may also be helpful, please explain why you are requesting financial assistance with this bill.

I HEREBY REQUEST THAT GRAND COUNTY EMS MAKE A DETERMINATION OF MY ELIGIBILITY FOR FINANCIAL AID. I UNDERSTAND THAT THE INFORMATION WHICH I SUBMIT CONCERNING MY ANNUAL INCOME AND FAMILY SIZE IS SUBJECT TO VERIFICATION BY GRAND COUNTY EMS. I ALSO UNDERSTAND THAT IF THE INFORMATION WHICH I SUBMIT IS DETERMINED TO BE FALSE, SUCH DETERMINATION WILL RESULT IN A DENIAL OF FINANCIAL AID AND THAT I WILL BE LIABLE FOR CHARGES FOR THE SERVICE PROVIDED. I UNDERSTAND THAT FINANCIAL AID WILL NOT BE AWARDED IF RECEIVED BENEFITS FROM MY INSURANCE COMPANY HAVE BEEN SENT DIRECTLY TO ME AND NOT FORWARDED TO GRAND COUNTY EMS TO BE APPLIED TO THE ACCOUNT BALANCE. I AFFIRM THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. FURTHER, I HEREBY GIVE MY PERMISSION TO GRAND COUNTY EMS TO VERIFY ANY INFORMATION PERTINENT TO THE APPLICATION. I UNDERSTAND IF AWARDED ASSISTANCE, I AM RESPONSIBLE FOR THE REMAINING BALANCE. A PAYMENT PLAN WILL BE ARRANGED AND IT IS MY RESPONSIBILITY TO ADHERE TO THE PAYMENT SCHEDULE. I UNDERSTAND IF I DO NOT MEET MY SET FINANCIAL OBLIGATIONS, GCEMS HAS THE AUTHORITY TO RETRACT MY AWARD AND I WILL BE RESPONSIBLE FOR THE ORIGINAL AMOUNT.

Patient's Signature (or legal guardian)

Date ____/____/____

Revised 04/13/2016