National Jewish Health®
Breathing Science is Life.®
1400 Jackson St. Attn: Financial Counseling Office A195 Denver, CO 80206
Phone: 303-398-1065 **Fax:** 303-270-2471 **Email:** FC@njhealth.org

FINANCIAL ASSISTANCE PROGRAM APPLICATION

Name of Applicant **SSN** **Date of Birth**

Name of Patient **SSN** **Date of Birth**

Address _____
Street **Apt#** **City** **State** **Zip Code**

_____ _____ _____
Home Phone **Cell Phone** **Work Phone**

List Names of All Dependents in Household

Name	Relation	Date of Birth	Social Security

Applicant/Responsible Parties Employer _____

Spouse/Partners Employer _____

Applicants Last 2 Months Income (Gross) **Spouse/Partners Last 2 Months Income (Gross)**

_____ _____

_____ _____

Total Gross Income **$0.00**

Income Sources Include: Employment, Self-Employment, Unemployment, Workman's Compensation, Short Term and Long Term Disability, Gifted Income, Social Security, Alimony, Old Age Pension, Pension Plans, Commissions, Tips, Trust Accounts, CD Accounts, Rental Income, Interest Income, and any other Income/Investment.

CHECK LIST OF REQUIRED DOCUMENTS

Please Provide Copies of All the Documents below that may Apply For Both Applicant and Spouse/Partner

- ☐ State Identification Card or Driver's License for all members 18 and over.
- ☐ Most recent employment income. Consecutive pay stubs for 1 full month for all dependents over the age of 18.
- ☐ Last year(s) complete tax return.
- ☐ Unemployment Income Award Notice and Balance Statement
- ☐ Social Security Income award letter(s).
- ☐ 2 Months self-employment ledger and detailed business bank account statements.

  NJH reserves the right to review monthly living expenses when calculating self-employment income

- ☐ Checking and Savings- detailed bank statements.
- ☐ Proof of marriage/divorce decree, or legal seperation document
- ☐ PAID receipts for medical/dental expenses for the 12 months prior to date of application.
- ☐ Medical expense payment plan(s) agreement/statement.
- ☐ Medicaid denial, if given, is required when applicable.
- ☐ Additional property value documentation.
- ☐ Asset/Liquid resources documentation (Money Market Accounts, Certificate of Deposits, IRA's, Investment Accounts, etc.)

· We cannot guarantee that you will qualify for financial assistance, even if you apply.

· Once you send in your application, we may verify all the information and may ask for additional information.

· Within 30 calendar days after we receive your completed application, with all required documentation, we will notify you if you qualify for assistance.

· Requested documentation not received within 45 days from the application date will result in an automatic denial which will be mailed to the responsible party.

· Applicants have up to 240 days from the first billing statement to request a reconsideration of an incomplete application. All required documentation will need to be resubmitted with the most recent, up to date information.

· All applicants will be required to apply for any state, federal, or local assistance for which they may be eligible, to help pay for any hospital/medical bill(s).

Applicant Agreement: I certify that the information in this application is true and correct to the best of my knowledge. I understand that the information provided in the application may be verified by National Jewish Health, and I authorize National Jewish Health to contact third parties to verify the accuracy of the information, including the review of an applicant's credit report history, for purposes of processing the application. I understand that if I knowingly provide untrue information in this application I will be ineligible for Financial Assistance, any Financial Assistance awarded may be reversed, and I will be responsible for payment of the entire bill(s). I understand that National Jewish Health has a right to recover. This means that if I am found to have a claim for any benefits payable, for any treatment which is given while I am eligible for National Jewish Health Financial Assistance, that National Jewish Health has the right to be included in the claims process.

_____

Print Applicant Name

_____ _____

Applicant Signature Date

Clients applying for or receiving discounted services shall:

1. Acknowledge that the NJFAP is not health insurance, does not offer a specific benefit package, is not an entitlement to medical benefits and that there are limitations to services discounted;

2. Give the NJ Patient Finance Office all the necessary financial information and documentation needed to complete the application;

4. Shall not give false information with the intent to commit fraud;

5. Inform the Patient Finance Office within 15 days if the NJFAP rating is disputed;

6. Be responsible for paying any money owed on time, and as required, or work with the Patient Business Office to make payment arrangements;

7. Notify the Patient Finance Office promptly of changes in resources, income and all other household changes that may affect the NJFAP rating;

8. Communicate any information, concerns and/or questions related to the financial screening to the appropriate representative;

10. Respect the property of the National Jewish Health , fellow clients and others; and

11. Follow all other rules and regulations of the NJFAP relating to respectful treatment and rights of other clients and provider staff.

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Worksheet 1 - Earned and Unearned Income

Payment Sources	Monthly Income	Documented	Annualized Income
Earned Income:			
Employment Income	$0.00		$0.00
Monthly Unearned Income Sources:			
		☐	$0.00
		☐	$0.00
		☐	$0.00
		☐	$0.00
		☐	$0.00
		☐	$0.00
		☐	$0.00
		☐	$0.00
		☐	$0.00
		☐	$0.00
		☐	$0.00
		☐	$0.00
		☐	$0.00
Annual or One Time Unearned Income Sources:			
		☐	$0.00
		☐	$0.00
		☐	$0.00
		☐	$0.00
		☐	$0.00
		☐	$0.00
		☐	$0.00
		☐	$0.00
Earned Income Total	$0.00		$0.00
Unearned Income Total	$0.00		$0.00
Total Income:			$0.00

#REF! #REF!

Facility Phone

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Worksheet 2 - Net Self-Employment Income

Does the applicant operate their business from their home?	No
Square footage of applicant's home:	
Square footage used for applicant's home business:	
Hours per week applicant works out of their home:	

		Monthly	Annualized
Revenue:			
	Gross Business Income		$0.00
Business Property Expenses:			
	Mortgage/Rent of Business Property		$0.00
	Utilities		$0.00
			$0.00
			$0.00
Other Expenses:			
	Advertising		$0.00
	Business Phone		$0.00
	Business Taxes (non-personal)		$0.00
	Fuel for Business-related Travel		$0.00
	Gross Wages		$0.00
	Insurance		$0.00
	Legal Fees		$0.00
	License/Certification Fees Paid		$0.00
	Merchandise/Cost of goods		$0.00
	Office Supplies		$0.00
	Repairs/Upkeep of Equipment		$0.00
	Tools/Equipment		$0.00
			$0.00
			$0.00
Total Expenses:		$0.00	$0.00
Net Profit		$0.00	$0.00 (use this figure on line 3, Section II of the CICP Application)

☐ **Applicant declares they have no Self Employment Income**

All information must be documented.

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Worksheet 3 - Allowable Deductions

Type of Deduction	Amount	Frequency	Documented	Annualized Amount
				$0.00
			☐	$0.00
			☐	$0.00
			☐	$0.00
			☐	$0.00
			☐	$0.00
			☐	$0.00
			☐	$0.00
			☐	$0.00
			☐	$0.00
			☐	$0.00
			☐	$0.00
			☐	$0.00
			☐	$0.00
			☐	$0.00
			☐	$0.00
			☐	$0.00
			☐	$0.00
			☐	$0.00
			☐	$0.00
		Grand Total:		$0.00

☐ **Applicant declares they have no deductions**

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Worksheet 4 - Liquid Resources - HOSPITAL AND HOSPITAL BASED CLINIC USE ONLY

Liquid Resources

Type of Liquid Resource	Value

TOTAL VALUE $0.00

☐ **Applicant declares they have no liquid resources**