National Jewish Health®

1400 Jackson St. Attn: Financial Counseling Office A102 Denver, CO 80206
Phone: 303-398-1065 **Fax:** 303-270-2471 **Email:** FinancialCounseling@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 _____

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 That Apply For Both Applicant and Spouse/Partner

- ☐ Last 2 consecutive months pay stubs for all dependents over the age of 18.
- ☐ Last year(s) complete tax return.
- ☐ Unemployment award notice.
- ☐ 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.
- ☐ Birth certificates for all family members; include proof of legal residency/citizenship for non-US birth certificates.
- ☐ Proof of marriage/divorce decree.
- ☐ 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 15-20 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 30 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.

_____ _____

Applicant Signature Date

NATIONAL JEWISH HEALTH FINANCIAL ASSISTANCE PROGRAM

FINAL RATING

For Office Use Only:

Total Resources	**$**
Family Size Deduction ($2500.00 per qualified member)	**$**
Equity in Resources	**$**
Total Family Financial Status	**$**
Allowable Deductions	**$**
Net Family Financial Status	**$**
Grand Total	**$**

Ability to Pay Rate_____
Client Co-Payment Cap_____
Effective From: _____ To:_____

I understand that it is my responsibility to notify National Jewish Health of an income or household change that may influence the rating on this application and failure to do so will void this application.

I understand that I have 15 days to appeal this rate.

_____
Print Applicant Name

_____ _____
Applicant Signature Date

Print Eligibility Technician Name_____

Eligibility Technician Signature and Date_____

NATIONAL JEWISH HEALTH FINANCIAL ASSISTANCE PROGRAM

Worksheet 1: Employment Income and Unearned Income

(For Office Use Only)

INCOME SOURCE	AMOUNT
Employment Income	**$**
Old Age Pension Benefits (OAP)/Aid to the Needy Disabled (AND)	**$**
SSI (Supplemental Security Income)	**$**
Investment Payment(s) and Retirement/Pension Plans **Source:_____ Source:_____** **Source:_____ Source:_____**	**$**
Commissions, Bonuses, Gifts and Tips	**$**
Alimony Received	**$**
Net Rental Income	**$**
Monetary Gains	**$**
Trust Accounts Funds	**$**
Settlements	**$**
Other Income: (Workman's Compensation, Short/Long Term Disability, Unemployment, etc.) **Source:_____ Source:_____** **Source:_____ Source:_____**	**$**
TOTAL	**$**
TOTAL (monthly amount) $_____ x 12 = Annual Income	**$**

LIQUID RESOURCES/ASSETS	AMOUNT
Investment Accounts: Total Value **(*CD's, Investments, Money Market, Whole Life Insurance Plans, IRA's etc.)***	**$**
Savings/Checking Accounts	**$**
Property Value(s)/Equity	**$**
Other:	**$**
TOTAL	**$**
TOTAL (monthly amount) $_____ x 12 = Annual Income	**$**

_____ _____ _____

Print Financial Counselor Name Financial Counselor Signature Date

NATIONAL JEWISH HEALTH FINANCIAL ASSISTANCE PROGRAM

Worksheet 2: Net Self-Employment Income

(For Office Use Only)

OCCUPATION TITLE/TYPE OF BUSINESS:_____

REVENUE	**ANNUAL**
Gross Business Deposits	**$**

EXPENSES	**MONTHLY**
Business Insurance	**$**
Labor/Payroll	**$**
Merchandise/Wholesale Cost of Inventory	**$**
Rent for Business Space	**$**
Interest on Business Mortgage	**$**
Business and Income Taxes	**$**
Equipment Upkeep and Maintenance	**$**
Utilities **Electricity $_____** **Phone/Data $_____** **Heat $_____**	**$**
Equipment	**$**
Supplies	**$**
Professional Services	**$**
Education, Licensing and Certification Fees	**$**
Business Related Travel	**$**
Other:	
TOTAL EXPENSES:	**$**
TOTAL NET PROFIT ($_____ x 12 = Yearly Total)	**$**

_____ _____ _____

Print Financial Counselor Name Financial Counselor Signature Date

NATIONAL JEWISH HEALTH FINANCIAL ASSISTANCE PROGRAM

Worksheet 3: Allowable Deductions

(For Office Use Only)

DEDUCTION	MONTHLY
Child Care/Day Care/Preschool	**$**
Court Ordered Alimony/Pension	**$**
Court Ordered Child Support	**$**
Health Insurance Premiums	**$**
Elder Care	**$**
Paid Medical Expenses **Provider:_____ Date Paid:_____ Amount:$_____** **Provider:_____ Date Paid:_____ Amount:$_____** **Provider:_____ Date Paid:_____ Amount:$_____** **Provider:_____ Date Paid:_____ Amount:$_____** **Provider:_____ Date Paid:_____ Amount:$_____**	**$**
Documented Monthly Payment Plan: (total outstanding balance)	**$**
Monthly Prescriptions	**$**
GRAND TOTAL	$

_____ _____ _____

Print Financial Counselor Name Financial Counselor Signature Date