

Access Management 380 West 100 North Monticello, Utah 84535 P: 435-587-1167 F: 435-587-2061

www.sanjuanhealth.org

## CHARITY CARE/SLIDING SCALE PROGRAM 2023 Application/Determination of Eligibility

Charity care has a 90-day retroactive policy for unpaid balances

It is strongly recommended that patients apply for Medicaid, as Medicaid in most cases will cover services at 100%.

MAILING ADDRESS:PO BOX/STREET	CITY/STATE	PHONE #:	
PO BOX/STREET	CITI/STATE	ZII CODE	
MPLOYER:	EMPLOYER PHONE #:		
HOUSEHOLD MEMBERS:			
NAME (First & Last)	DATE OF BIRTH	RELATIONSHIP	INSURANCE PLAN, if any
If additional household member, please use a	nother sheet of paper and lis	t all information for each.	

## HOUSEHOLD INCOME:

Income Type	Head of Household Income per year	Other Household Member Income	Type of Income Verification Required	
Employment Income (Gross)			Provide most recent tax return or paycheck stubs for the last three pay periods	
Self-Employment Income (Gross)	,		Provide 3 months bank statements <u>and</u> most recent tax return	
Pension, Retirement, Social Security Income			Provide your Pension/Retirement/Social Security award letter	
Unemployment, Disability Income, etc.			Provide unemployment, disability award letter	
Child Support, Alimony			Provide a copy of your divorce decree, legal separation notice or custody agreement	
Other (Please list source) Family, Church, etc.			Provide a written explanation of your income source	

Application continued on back

	should be informed of to understand ation/verifications required. You may			
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be approved. Also, we will	n the previous year and/or other in need proof of address (Drivers Lic., s submitted with the application!		•	
I certify that the household s	ize and household income information	tion shown above is correct	t.	
NAME (Print):	SIGNATURE:		DATE	:
supporting documentation c	out the program, you can call Heatl an be returned to the clinic, the hos or mailed to: Attention Heather: P.	spital front desk, faxed to:	435-587-2061, e	
are offered based on house return to Access Managem Please remember to include	Health to provide essential service hold size and gross annual incoment to determine if you and member to the federal ermined according to the federal	ne. Please complete the factorial place in th	following information in formation in the second contract of the sec	mation and a discount.
are purchased from outside radiologist, elective surgeri	o applicable services received at S e, including reference laboratory t es, colonoscopies, and other such e if your insurance status or finan	testing, drugs, and x-ray r n services. <b>This form must</b>	reading by a co	nsulting
	*OFFICE US	E ONLY*		
Approved Discount:	Visit Payment:	Date Complet	ed:	
Approved By:		Date Eligibility Letter S	Sent:	
	VERIFICATION CHECKLIST		YES	NO
Identification/Address: Driver's Licens	e, Utility Bill, other ID			
Income: Prior year Tax Return, Three r	nost recent paystubs or other income			
Insurance: Insurance Cards				