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 2025

Application/Determination of Eligibility

It is the policy of San Juan Health to provide essential services regardless of the patient's ability to pay. Discounts are based on household size and gross annual income. The maximum gross income per year (200% of the Federal Poverty Guidelines) for one person would be $31,300, (add $11,000 for each additional member). Please complete the following information and return to Access Management to determine if your household is eligible for a discount. **No discount will be awarded to those who do not complete the application process. This program has a 90-day retroactive policy for unpaid balances, and copays are exempt from discounts.**

HOUSEHOLD MEMBERS:

NAME (First & Last)	DATE OF BIRTH	RELATIONSHIP	INSURANCE PLAN, if any
		Self	

YEARLY 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 and paycheck stubs for the last three pay periods**
Self-Employment Income (Gross)			**Provide 3 months bank statements and 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**

MAILING ADDRESS: _____ **PHONE #:** _____
PO BOX/STREET **CITY/STATE** **ZIP CODE**

EMPLOYER: _____ **EMPLOYER PHONE #:**_____

Please explain any situation we should be informed of to understand your inability to pay your medical balances or use for explaining why you cannot get the information/verifications required. You may attach a separate sheet if more space is needed.

_____

_____

_____

_____

_____

_____

_____

This form must be completed each year or if your insurance status or financial situation changes by more than $250 a month.

****Copies of Tax Returns from the previous year and/or other information verifying income is required before a discount will be approved. Also, we will need proof of address (Drivers Lic., ID, Utility Bill, etc.). Please note that some services are not covered by this program. Some of which are: chemotherapy, drugs, elective surgeries, colonoscopies, health fair labs, any services sent to or performed at another facility--including radiology reading services.** It is not required, but strongly recommended that patients apply for Medicaid.

I certify that the household size and household income information shown above is correct.

NAME (Print): _____ **SIGNATURE:** _____ **DATE:** _____

VERIFICATION CHECKLIST	YES	NO
Identification/Address: Driver's License, Utility Bill, other ID		
Income: Prior year Tax Return, Three most recent paystubs, SSI, Child support/alimony or other income		
Income: Family or church assistance		
Insurance: Insurance Cards		
Is this related to a car accident? If yes, please provide insurance information		
Medicaid denial, if applied?		

If you have any questions about the program, you can call Heather @ 435-587-1167. Once completed, the form and supporting documentation can be returned to the clinic, the hospital front desk, faxed to: 435-587-2061, emailed to: hstocks@sanjuanhealth.org, or mailed to: Attention Heather: P.O. Box 308 Monticello UT, 84535.

OFFICE USE ONLY

Total Gross income: _____

Approved Hospital Discount: _____% Approved Clinic Discount: _____% Visit Payment: $_____ Date Completed: _____