PAGOSA SPRINGS
Medical Center
THE CARE YOU DESERVE, IN THE MOUNTAINS YOU LOVE

Financial Assistance Application for PSMC Hospital

Need assistance call 970.507.3939 or 970.507.3942

Patient's Name:_____MRN#_____Date_____

In order for a Financial Assistance request to be processed, the following information MUST be returned with this application. If you cannot provide the following please explain: (I certify that the information provided is true & complete)

- Most recent pay stubs or Supplemental Security Income (SSI provided by Social Security)
- Most recent statements from checkings, savings, certificates of deposit, stocks, bonds, money market, etc.
- Most recent Federal Income tax forms including schedules, C, D, E, & F
- Most recent W2 statement or 1099

Do you own your Home ___yes___no Estimate value_____Mo. Mortgage/Rent_____

Guarantor Name :_____Relationship to Patient_____SS#_____
(Head of household)

Spouse's Name if Married_____SS#_____Phone_____

Street Address:_____City_____State___Zip_____

How many dependents live in household?_____Please list total family members in household_____

List Monthly Income:

Employment_____SSI_____Alimony/Child support_____Pension_____

Trust Fund_____Public Assistance_____Investment Income_____Rental Income_____

I certify that the information provided is true and accurate. I hereby agree to file an application for Medicaid and advise Pagosa Springs Medical Center of the approval or denial of the application so my Financial Assistance application can be processed.

Signature of Applicant:_____Date_____

For Pagosa Springs Medical Center Use Only

Adjustment totals:_____Adjustment Alias_____Financial Asst. Category_____

Approvals: Manager _____Date_____

Director_____Date_____

CFO_____Date_____

Percentage of FPL Guidelines is_____Approved if below_____of FPL Guidelines

Reviewed / Revised 11/27/2018, 11/25/2020