Patients applying for financial assistance from Johnson County Memorial Hospital and/or Family Medical Center

This application only applies to **residents of Johnson County, Wyoming** that have current account balances with Johnson County Memorial Hospital and/or Family Medical Center. Balances that are in collection and are at legal status may not be considered for assistance.

The qualifying amount is based on the government's poverty levels for corresponding number of dependents in your household, and calculated from your gross income.

If you do not have insurance, please provide proof of denial from the State of Wyoming Medicaid Program. You can apply for Medicaid online at: https://govthub.com/wyoming-benefits-guide.aspx .

Please provide a letter outlining why you are applying for financial assistance such as medical reasons or financial hardship. Should you base your reason for assistance as medical, you will need to provide proof of medical condition from your doctor explaining why you are unable to work.

A copy of your current income tax return must be provided along with other documentation listed on the first page of the application.

If you have not filed taxes for the current year, you will need to contact the internal revenue service at 1-800-829-1040 and request written proof of your tax status for the current year. You can also make this request online at http://irs.gov/individuals/get-transcript .

2022 Poverty Guideline (add $4,720 for each additional person over 8)

People in Household	100%	101-200%	201-250%	251-275%
1	$ 13,590	$ 27,180	$ 33,975	$ 37,373
2	$ 18,310	$ 36,620	$ 45,775	$ 50,353
3	$ 23,030	$ 46,060	$ 57,575	$ 63,333
4	$ 27,750	$ 55,500	$ 69,375	$ 76,313
5	$ 32,470	$ 64,940	$ 81,175	$ 89,293
6	$ 37,190	$ 74,380	$ 92,975	$ 102,273
7	$ 41,910	$ 83,820	$ 104,775	$ 115,253
8	$ 46,630	$ 93,260	$ 116,575	$ 128,233
Percent Patient Will Pay	**0%**	**25%**	**50%**	**75%**

FINANCIAL ASSISTANCE PROGRAM

Applicant Name		Spouse Name	
Social Security Number		Social Security Number	
Date of Birth		Date of Birth	
Physical Address		Physical Address, if different	
Mailing Address		Mailing Address, if different	
Home Phone Number		Home Phone Number, if different	
Cell Phone Number		Cell Phone Number	
Current Employment		Current Employment	
Occupation		Occupation	
How Long Employed?		How Long Employed?	
Employer Phone Number		Employer Phone Number	
Gross Pay	Weekly; Monthly, etc.	Gross Pay	Weekly; Monthly, etc.
Net Pay	Weekly; Monthly, etc.	Net Pay	Weekly; Monthly, etc.
Other Income		Other Income	
Source		Source	

Number of Dependents: _____

The Applicant and Co-Applicant must provide copies of the following:

- ☐ Current Pay Stubs for entire household for the past two (2) months
- ☐ Current year tax returns
- ☐ Proof of other income (SSI, SSDI, Child Support, Unemployment Benefits, or Worker's Compensation)
- ☐ Current Bank Statements for Checking and/or savings for past two (2) months
- ☐ Divorce Decree (if applicable)
- ☐ Letter explaining need for financial assistance
- ☐ Denial letter from bank on home equity line of credit if you own your home
- ☐ Denial from Medicaid for coverage is uninsured

Please return your personal financial statement and the requested documentation no later than _____

What amount can you pay monthly should your application be denied or you have a remaining balance? _____

Checking Account ☐ Yes ☐ No

If Yes, Name of Bank	Account Number

Savings Account ☐ Yes ☐ No

If Yes, Name of Bank	Account Number

Do you have income from Dividends, Interest, Stocks, Trust Fund, Bonds, Certificates of Deposit, etc.?
☐ Yes ☐ No If yes, total income per year?_____

Insurance? ☐ Yes ☐ No
If yes, name of Company _____
Address_____

Are you a defendant in any suits or legal actions? ☐ Yes ☐ No

Have you declared bankruptcy? ☐ Yes ☐ No
If yes, date filed_____ date discharged _____

Do you have any contingent liabilities? ☐ Yes ☐ No
If yes to any of the above, please explain below:_____

_____

_____

Please List Monthly Payments Paid Each Month

Mortgage/ Rent Payments _____

Mortgage/Rent Insurance_____

Food		Credit cards	
Electricity		Store charges	
Heat		Personal loans	
Water		Auto loan	
Garbage		Auto Maintenance	
Phone		Auto Insurance	
Cable/Internet		Auto Fuel	
Medical Insurance		Alimony	
Prescriptions		Child Support	
Medical Bills		Personal Expenses	

I understand that the purpose of this information is to assist the Johnson County Memorial Hospital and/or Family Medical Center in determining financial assistance or to arrange an extended payment plan mutually acceptable for me and the Johnson County Memorial Hospital and/or Family Medical Center. The above information is true and correct. I understand the information submitted is subject to verification; therefore, I grant permission and authorize any bank, insurance company, real estate company, financial institution and credit grantor of any kind to disclose to any authorized agent of Johnson County Memorial Hospital and/or Family Medical Center information as to my past and present accounts, policies, experiences and all pertinent information related thereto. I authorize Johnson County Memorial Hospital and/or Family Medical Center to perform a credit check for both guarantor/patient and spouse.

_____

Signature of person(s) financially responsible Date Signed

_____

Signature of person(s) financially responsible Date Signed

REVIEW OF FINANCIAL ASSISTANCE

Patient(s): _____

For Office Use Only:

Current Income		
Average Yearly Income		
Max. income allowance under policy guidelines recommendation		
Approved Date		
Percent Approved		
Amount Approved		
Account Number		Balance:
Account Number		Balance:
Denied Date		