Boulder Community Health

FINANCIAL ASSISTANCE APPLICATION

Thank you for your interest in being screened for Financial Assistance at Boulder Community Health. In order to process your application, we will need copies of the following information. Please submit the information as soon as possible.

1. Proof of address (identification card, driver's license, rental agreement, bank statement or utility bill)

2. Employment income from all working non-student adults ages 18 and older. Please provide a copy of last month's paycheck stubs or a letter from employer stating gross income earned for last month. Two 2-week stubs or four 1-week stubs are acceptable. If married, include spouse income. If you need to provide more than one month for a good average, you may do so.

3. Self-Employment income from all working non-student adults ages 18 and older, you may use bank statements, a profit and loss sheet, ledgers, logs, invoices, receipts, etc. to show your income. You may use a separate sheet for business expenses. Information must be current. Please start with last month and turn in as many months as needed to show a good average, with at least 3 months preferred. Please call 303-415-4718 for more information, if necessary.

4. Unearned income for all household members: Social Security income, either SSI or SSDI, Short-Term Disability Income, disbursements from retirement accounts, pension payments, payments from trust funds, disbursement from lottery winnings and unemployment income. (SSI and SSDI payments are not required for minors or adults with disabilities who are still under the care of their parents or guardian)

5. A hardship letter may be included to explain your situation.

6. Please fill out and sign the 2nd page of this application.

You **MUST** provide all information listed above that pertains to you. If this information is not returned with the application, it will be considered incomplete, and we will not be able to process your application.

Please note:
Once all the documentation listed above is submitted, we will mail you a determination letter explaining if you were approved or denied for financial assistance through The Colorado Indigent Care Program (CICP) and/or Hospital Discounted Care (HDC). If we end up determining you are not eligible for CICP and/or HDC but appear eligible for our in-house financial assistance program WeCare, we will request additional documentation (liquid asset documentation for last month) to be screened for WeCare. To be eligible for WeCare your gross household income and assets must be within 251%-350% of the federal poverty level. For more information on WeCare eligibility, please view our Financial Assistance Policy at https://www.bch.org/patient-visitors/patient-services/financial-assistance/

Please mail or email the completed application, along with all documentation to:

Patient Service Center
ATTN: Financial Assistance
Boulder Community Health
PO Box 9049
Boulder, CO 80301

Email: financialassistance@bch.org Please call 303-415-4718 with any questions.

Patient Name: _____

Responsible Party info:
Name:_____DOB:_____
Address:_____Phone#:_____
Employer: _____Length of employment: _____

Spouse info:
Name:_____DOB:_____
Employer: _____Length of employment: _____

Household Members:
Name: _____ Relationship to patient: _____
DOB: _____
Name: _____ Relationship to patient: _____
DOB: _____
Name: _____ Relationship to patient: _____
DOB: _____
Name: _____ Relationship to patient: _____
DOB: _____
Name: _____ Relationship to patient: _____
DOB: _____

I hereby certify that to the best of my knowledge and belief, the information listed on this statement and the information I have provided is true and complete.

Applicant signature: _____ Date: _____

Updated 7/1/2024