Colorado Canyons
HOSPITAL & MEDICAL CENTER

PO Box 130 ● 300 W. Ottley Ave
Fruita CO 81521

APPLICATION FOR FINANCIAL ASSISTANCE

DATE ISSUED: _____

Name				Number of People in Household	
Address					
Employer		Address		Phone #	

ACCOUNTS WITH COLORADO CANYONS HOSPITAL

Patient's Name	Account #	Date of Service	Amount Due
		Total Amount Due:	$ 0.00

INCOME: If employed, submit copies of paycheck stubs for patient and spouse (showing one full current month of income). Include documentation of additional income for the household (alimony, child support, etc.). If unemployed, submit documentation of weekly/monthly unemployment income.

Attached	Monthly Income	Amount		Attached	Monthly Income	Amount
☐	Wages			☐	Worker's Comp	
☐	Commissions/Tips			☐	Rental	
☐	Self-Employment			☐	Interest	
☐	Unemployment			☐	Alimony / Maintenance	
☐	Social Security			☐	Child Support	
☐	Retirement / Pension			☐	Other:	

EXPENSES: Please list all expenses that affect your ability to pay your medical bills. Include copies of bills/statements covering the past full month.

Attached	Monthly Expenses	Amount		Attached	Monthly Expenses	Amount
☐	Rent			☐	Auto Gas	
☐	Mortgage			☐	Insurance / Auto	
☐	Electricity			☐	Insurance / Health	
☐	Gas / Propane			☐	Insurance / Life	
☐	Water			☐	Prescriptions	
☐	Sewer			☐	Other Medical	
☐	Trash			☐	Child Support	
☐	Phone			☐	Alimony	
☐	Cell Phone			☐	Cable TV	
☐	Newspaper			☐	Daycare	
☐	Internet Access			☐	Loan Payment	
☐	Groceries			☐	Mesa County Taxes	

I/We hereby certify that the information listed herein is true and correct to the best of my/our knowledge and give Colorado Canyons Hospital my/our permission to verify any information listed. I/We understand that if I/we am/are granted financial assistance and I/we fail to meet my/our obligation to resolve any outstanding balance by either payment in full or by establishing a payment plan, all financial assistance will be reversed and the full balance will be sent to collections.

Signature of Applicant: _____ **Date:** _____