Grover C. Dils Medical Center
Bringing Quality Healthcare to the High Desert

Financial Application Check List

Please provide the following information when submitting your application:

1. A brief letter explaining your current situation and why you need assistance with your medical bills.
2. **Copies** of last 30 days income from employer, award letter from Social Security, Retirement, Disability, Unemployment, etc. to show proof of income.
3. **Copies** of your last two years tax returns OR copies of your last 3 bank statements if you did not file taxes, to show proof of income.
4. Any other information you feel may be necessary in consideration of your application.

This information should be completed and returned as soon as possible. There may be additional requests for information and once your application is processed and reviewed, you will be notified of a decision in writing. Please note, **eligibility is determined only based on family size and income, so all household proof of income must be provided.**

You may deliver your application and information in person to the hospital or clinic registration desk, or mail to:

GCDMC/LCMA PATIENT FINANCIAL ADVOCATE
Patient Financial Services
PO BOX 1010 Caliente, NV 89008

For questions or assistance please contact April Nelson at 775-726-8011 or email anelson@gcdmc.org

Grover C. Dils Medical Center
Bringing Quality Healthcare to the High Desert

FINANCIAL ASSISTANCE APPLICATION

Please note: Eligibility is determined only by input of family size and income

DATE OF APPLICATION _____

1. PATIENT INFORMATION * - PLEASE PRINT ALL INFORMATION -			
Last Name	**First Name**	**Middle Name**	**Medical Record Number** (Hospital Use)

- If the patient is a minor, please list parent(s)/guardian(s) as applicant and co-applicant

2. APPLICANT (GUARANTOR) INFORMATION				
RELATIONSHIP TO PATIENT □ Self □ Spouse/Domestic Partner □ Parent □ Other _____				
MARITAL STATUS (Optional) □ Single □ Widow □ Married/Domestic Partner □ Divorced □ Separated				
Last Name	**First Name**	**Middle Name**	**Social Security Number**	**U.S. Citizen** □ Yes □ No

Date of Birth	**No. of Dependents** (other than self & co-applicant)	**Ages of Dependents**	**Home Phone Number** ( )

Street Address (Do Not List PO Box)	**City**	**State**	**County**	**Zip**
Mailing Address	**City**	**State**	**County**	**Zip**
Current Employer	**Complete Address**		**Current Position**	
*** IF NOT WORKING, HOW LONG HAVE YOU BEEN UNEMPLOYED?**				

3. CO-APPLICANT (GUARANTOR/PARENTAL) INFORMATION RELATIONSHIP TO PATIENT □Spouse/Domestic Partner □ Parent □ Other _____					
Last Name	**First Name**	**Middle Name**	**Social Security Number**		**U.S. Citizen □ Yes □ No**
Date of Birth	**No. of Dependents** (other than self & co-applicant)	**Ages of Dependents**	**Home Phone Number** ( )		
Street Address (Do Not List PO Box)		**City**	**State**	**County**	**Zip**
Mailing Address		**City**	**State**	**County**	**Zip**
Current Employer		**Complete Address**		**Current Position**	

*** IF NOT WORKING, HOW LONG HAVE YOU BEEN UNEMPLOYED?**

4. FINANCIAL ASSISTANCE QUESTIONS: ALL ANSWERS PERTAIN TO THE PATIENT		
		Check Appropriate Answer
1.	Is the patient applying for assistance with bills for past services at Grover C. Dils Medical Center and/or Lincoln County Medical Associates? If yes, please indicate the last service date: _____	□ Yes □ No
2.	Is the patient applying for assistance with bills for current and/or future services at Grover C. Dils Medical Center and/or Lincoln County Medical Associates? If yes, please indicate/describe the types of services anticipated: _____ _____	□ Yes □ No
3.	Is the patient applying for a discount off their bills from Grover C. Dils Medical Center and/or Lincoln County Medical Associates?	□ Yes □ No
4.	Is the patient applying for 100% assistance with their bills for services provided at Grover C. Dils Medical Center and/or Lincoln County Medical Associates?	□ Yes □ No
5.	Does the patient have health insurance that has not been previously provided for billing? If yes, please provide the following information: Health Insurance Co. Name: _____ Subscribers Name: _____ Member/Patients Identification Number: _____Group Number: _____ Group/Employer Name: _____ Effective Date: _____ Health Insurance Telephone Number: _____	□ Yes □ No

6.	Is the patient being treated for injuries covered by Workers Compensation? If yes, please provide the following information: Name of Work Comp Carrier: _____ Adjusters Name: _____ Adjusters Phone Number: _____	□ Yes □ No
7.	Is the patient being treated for injuries covered by Third Party Liability such as an Auto Insurance Company? If yes, please provide the following information: Name of Auto Insurance or Attorney: _____ Auto Insurance or Attorney Phone Number: _____ Injury Date: _____ Claim/Case Number _____	□ Yes □ No
8.	Is the patient a Victim of Crime? If yes, please provide the following information: Date of Injury: _____ Name of Case Worker: _____ Case Workers Phone Number: _____ Case Number: _____	□ Yes □ No

5. INCOME INFORMATION (To document additional income use Section 7 or 8 of this application)			
Monthly Income Sources	**Applicant**	**Co-Applicant**	**Combined Monthly Income**
Employment Income	$	$	$
Social Security	$	$	$
Disability	$	$	$
Unemployment	$	$	$
Spousal/Child Support	$	$	$
Rental Property	$	$	$
Investment Income	$	$	$
Other(s) use these spaces	$	$	$
	$	$	$
	$	$	$
	$	$	$
		Total Combined Monthly Income	$
Unemployment: If you do not have monthly income, please explain how you take care of your monthly expenses:			

6. ASSETS (To document additional assets use Page 4 of this application)			
Checking/Money Market/Saving Accounts: ** List all available funds.**			
Bank Name:	**Branch Address**	**Account Number**	**Current Balance**
1.			$
2.			$
3.			$

7. ESTIMATED MONTHLY LIVING EXPENSES (to document additional monthly expenses use Section 8)			
Monthly Expenses	**Monthly Payment**	**Monthly Expenses**	**Monthly Payment**
House/Mortgage Payment	$	Health Insurance Premiums	$
Property Taxes (if not Included in mortgage payment)	$	Total Monthly Automobile Payment(s)	$
Home Owners Insurance (if not Included in mortgage payment)	$	Automobile Insurance	$
Utilities (Electricity, Gas, Water, Garbage, Recycling, etc.…)	$	Automobile Gasoline	$
Food	$	Liens/Wage Garnishments	$
Telephone (home line and/or cell)	$	List Other Monthly Payments	$
Child Support	$		$
Spousal Support Alimony	$		$
Child Care	$		$
Credit Cards	$		
		Total Monthly Payments	$

8. ADDITIONAL INFORMATION & COMMENTS:

ADDITIONAL COMMENTS – IF YOU NEED MORE SPACE, PLEASE USE BACK OF THIS PAGE

9. SIGNATURE

I certify that all information is valid and complete and hereby authorize Grover C. Dils Medical Center and/or Lincoln County Medical Associates to request a credit check report and/or verify any of the above information as deemed necessary.

APPLICANT	DATE	CO-APPLICANT	DATE
_____	_____	_____	_____

RETURN COMPLETED APPLICATION TO:

Patient Financial Service

GCDMC/LCMA PATIENT FINANCIAL ADVOCATE

PO BOX 1010
Caliente, NV 89008-1010