MIND SPRINGS *health* Prevention. Care. Recovery. WEST SPRINGS *hospital* Psychiatric Care & Recovery

Application for Financial Assistance

Client Name _____ Date of Birth _____ SSN _____
Billing Address _____
Phone Number_____ ☐ I am homeless. I have no permanent night time residence
Is the patient claimed as a dependent on anyone's taxes? YES NO Who claims the dependent? _____
Does the client have insurance? YES NO Primary Insurance _____ *Please attach a copy of the card*
Has the client applied for Medicaid YES NO Date applied _____
Is the patient currently incarcerated? YES NO How long? _____

Household is defined as any person that receives 50% of their financial support from the household.

1	List all Household Members	Relationship	Date of Birth	Employer	Gross Income
2					
3					
4					
5					
				Annual Household Gross Income	

Please include child support received, alimony, Social Security, disability, and any other sources of income

☐ I am currently unemployed and have no source of income at this time.

☐ I do not qualify for unemployment benefits

If applicable, please complete zero income form

WEST SPRINGS HOSPITAL/TRANSITIONS AT WEST SPRINGS ONLY

☐ I approve WSH/TWS to contact my employer to obtain my income verification to evaluate for a fee reduction
☐ I do not approve WSH/TWS to contact my employer for income verification

If client agrees to contact employer, please complete the ROI form

Additional Information:

I hereby certify that the information listed herein is correct to the best of my knowledge and give Mind Springs Health/West Springs Hospital/Transitions at West Springs permission to verify any information listed. I understand that if I do not supply proof of income I will be expected to pay the balance that has been deemed my responsibility in full.

Patient or authorized representative signature _____

Print name _____ Date _____

Should you have any questions, a financial counselor is available to assist you
Monday – Friday from 8:00AM to 4PM toll free 1-888-320-5218

MSH/WSH Staff ONLY
Staff_____
SFS rating_____ Date approved_____

Mind Springs Health
West Springs Hospital
Transitions at West Springs

P.O. Box 3807
Grand Junction, CO 81502
1.888.320.5218