TELLURIDE MEDICAL CENTER

FINANCIAL ASSISTANCE APPLICATION

APPLICANT INFORMATION: (print, please)

Name: _____ Date of Birth: ___/___/___

Phone #: _____

Mailing address: _____

How many months per year do you work? _____

Do you have a bank account? YES ☐ NO ☐

Tax return? YES ☐ NO ☐

OTHER INCOME EARNING FAMILY MEMBER IN HOUSEHOLD:

Please, include proof of income for these people as well.

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

DEPENDENTS: All persons in your household who don't work.

Name: _____ DOB: ___/___/___Relation: _____

Name:_____ DOB:___/___/___ Relation:_____

Name:_____ DOB:___/___/___ Relation:_____

Name:_____ DOB:___/___/___ Relation:_____

Name:_____ DOB:___/___/___ Relation:_____

"I attest under penalty of perjury that the aforementioned information is complete and correct."

SIGNATURE: _____ **DATE:** _____ /_____ /_____

PO Box 1229 - 500 W Pacific Ave, Telluride, CO 81435 - www.tellmed.org - (970) 728-3848 - Fax: (970) 728-3404

TELLURIDE
REGIONAL MEDICAL CENTER

FINANCIAL ASSISTANCE APPLICATION INSTRUCTIONS

The Telluride Regional Medical Center provides quality health care to all residents of the Telluride Hospital District regardless of their ability to pay.
If you have any questions, or need help in completing this application, please call or text Cali al 970.708.8745.

INSTRUCTIONS:

1. Complete,sign and attach all required documents.
2. You can also mail the application and required documents to:
   Telluride Medical Center P.O. Box 1229 Telluride, CO 81435
   or fax 970-728-3404.

REQUIRED DOCUMENTS:

Medicaid letter of denial AND at least two of the three items listed below:

1. Previous year's tax return.
2. Last three paystubs or income verification.
3. Last three bank statements from all bank accounts.

*If you work for cash, you'll need to sign an Affidavit with your income information.

Non-Working Applicant:

1. Documentation of sources of assistance or support (letters from family, lenders, other assistance programs, etc.).
2. Bank statements from last 3 months, credit card statements, trust, savings and investment account statements.
3. Medical Assistance Determination (proof of Medicaid denial).

MEDICAID APPLICATION INFORMATION

(Qualification is based on income and family size)

ONLINE: www.colorado.gov/hcpf

or

CALL TRI-COUNTY at 970.708.7096

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