Medical Hardship: Medical hardship is done case-by-case and/or once you have applied for all Medical Assistance programs and have been denied. However, to be qualified for applying for a Medical Hardship you must fill out application and present to us ALL the requested documentation below. Use this checklist as a reference on what to gather and bring in along with your application.

MEDICAL HARDSHIP CHECKLIST:

Medical Hardship Application filled out and signed
Identification/ Photo I.D
Proof of Residency
Insurance Cards (If applicable)
Provide proof of <u>ALL</u> aspects of income
Provide Copies of EVERY & ANY BILL you have
Assistance Denial Letters (Medicaid, Indigent,
Charity Care, Or other)
Bring recent bank statements backdated 3 months
to current

SIERRA VISTA HOSPITAL AND CLINICS

Sierra Vista HospitalMedical Hardship Application

Please complete the following information and return application and ALL requested documentation to the Financial Counselor to determine if you qualify for a medical hardship. If approved, the discount will apply to all services received at Sierra Vista Hospital.

Name				
Address:		City:		
State:	Zip:		Phone:	
Current Sierra Vista Hospital ou	tstanding patien	t balance: _		

Please list ALL sources of income.

Source	Self	Spouse	Other	Total
Gross wages, salaries, tips, etc.				
Income from business, self-employment, and dependents				
Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pensions, or retirements				
Interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household				
Any miscellaneous sources				
Total Income				

Please list <u>ALL</u> and <u>ANY</u> bills you pay each month. You must attach copies of each bill to this application.

Bill	Name	Bill Type	Total
TOTAL:			
I certify that all the info	rmation shown above is corre	ect.	
Signature	 Date	Name (Print)	

	Office Use Only			
Patient Name:	Patier	nt ID #:		
BO Application Preparer:	Date:			
Verificatio	on Check List		Yes	No
Identification/Address: Driver's license, utility	y bill, employment ID, c	or another form		
Income: Prior year tax return, three most reco	ent pay stubs, or other			
Other Assistance Denial Letters: Medicaid, Inc	digent, Charity, or othe	r		
Bills: Bills listed on application accommodate	d with copies of each b	pill		
BO Manger Signature:		Date:		
Interim CFO Signature:		Date:		
Approved: Yes/No				
NOTES:				
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