SAN JUAN REGIONAL MEDICAL CENTER

801 West Maple Street • Farmington, NM 87401
Telephone: 505.609.2000 • sanjuanregional.com

San Juan Regional Medical Center Financial Assistance Policy Application

SECTION A: APPLICANT INFORMATION

Patient's name: _____

Account number: _____

Mailing address: _____

City, State, Zip: _____

Physical address: _____

City, State, Zip: _____

Social Security Number: _____ Date of Birth: _____

Phone Number: ☐ Cell ☐ Home ☐ Work _____

Email address: _____

Marital Status: ☐ Married ☐ Divorced ☐ Widow(er) ☐ Domestic Partner ☐ Single

Definition of Household Size: Patient/guarantor; Spouse/domestic partner of patient/guarantor; Any adult living in household 51%+ of the time; Biological, adoptive or step children living in household 51%+ of the time; Children related to patient/guarantor within fifth degree by blood or marriage living in household 51%+ of the time; Dependent children who are 18 years old, still in high school; Unborn fetus is counted as a household member.

List all members of the household Resident's Name	Age	Student (Y/N)	Employed (Y/N)	How many months per year resides in household?	Who claims as dependent on Federal/State Income

Employment status: Currently employed? ☐ Yes ☐ No
Spouse/domestic partner employed? ☐ Yes ☐ No

If unemployed, your previous employer: _____

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Employed there for how long? _____

SECTION B: CURRENT MONTHLY GROSS INCOME (REQUIRED—All income from household must be reported.)

If your household income is zero, a written letter that explains your means of living is required with your application.

Who is the primary wage earner? (check one)	☐ Patient	☐ Spouse/Other
Gross monthly salary/wages (before taxes)	$_____	$_____
Cash income (not including gifts)	$_____	$_____
Gross Social Security income	$_____	$_____
Other income: ☐ Unemployment benefit	$_____	$_____
☐ State disability income	$_____	$_____
☐ Alimony or child support	$_____	$_____
☐ Pension income	$_____	$_____
☐ Rental property income	$_____	$_____
☐ Self-employment income	$_____	$_____
☐ Other sources (describe)		
_____	$_____	$_____
Total monthly income:	$_____	$_____

Please include supporting documents such as paystubs, statements, and cancelled checks. When reporting rental or self-employment income, you must include your most recent tax return, along with all supporting schedules.

SECTION C: ADDITIONAL INCOME INFORMATION

Are you qualified for any of the following government programs:?

SNAP: ☐ Yes ☐ No Medicaid: ☐ Yes ☐ No

TANF: ☐ Yes ☐ No SSI: ☐ Yes ☐ No

Landlord or mortgage holder's name and contact information: _____

_____

If there are circumstances relating to the Patient's and/or Patient's family financial situation of which you need us to be aware, please list them here (add an additional sheet if needed). _____

_____

_____

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SECTION D: MISSING INCOME DOCUMENTATION

If you do not have income documentation, your signed attestation in this application may satisfy the income verification requirement if you meet any of the following criteria:

- ☐ I don't receive a formal pay stub from my employer
- ☐ I receive no income. (If you check this box, you must provide written explanation of financial situation.)
- ☐ I was not required to file a recent Federal of State Tax Return for the most recent tax year.

SECTION E: FINANCIAL AGREEMENT AND CREDIT REPORT AUTHORIZATION

I hereby declare under penalty of perjury that all information set forth in this application is true and accurate in all respects, and that all attachments are accurate copies of the original documents;

Or, I am unable to provide documents relating to proof of income or other evidence of my income.

I authorize employees and agents of San Juan Regional Medical Center to investigate and verify the information I have provided, including employment and credit history for the purpose of determining my eligibility to participate in the Financial Assistance Program. I am aware that falsification or misrepresentation of information on this application may result in denial of or disqualification after receiving financial assistance. I also acknowledge and agree that I am liable to SJRMC for all amounts owing that are not covered by the FAP.

Patient/Guarantor Signature: _____ Date:_____

Spouse Signature: _____ Date:_____

FOR INTERNAL USE ONLY

DATE RECEIVED: _____

Application complete: ☐ Yes ☐ No Completion info sent: ___(date)___ Completion call: ___(date)___

Additional information due: _____(date)_____ Information received: ☐ Yes ☐ No

Qualifies for: ☐ Medicaid Application date: _____ ☐ Approved ☐ Denied

☐ Payment plan ☐ Self-pay (15%)

☐ SJC Indigent Fund Application date: _____ ☐ Approved ☐ Denied

☐ FAP AGB $: _____ Discount %: _____ Total Due: _____

All accounts to which this applies: _____

_____

Date all processing complete: _____

Mission: Better is our mission, improving lives through personalized health and care.