SUMMITSTONE HEALTH PARTNERS

PH: (970) 494-4200
FX: (844) 270-1824

4856 INNOVATION DR. STE. B
FORT COLLINS, CO 80525

Dear Client or Applicant,

In some instances, SummitStone Health Partners can provide financial assistance to our clients. To see if you qualify for this assistance, please complete all the questions on the attached Financial Application. We also need a **copy of at least one of the following items** to make this determination:

_____ Current tax return (1040 first two pages only)

_____ Social Security/Social Security Disability Income (SSDI)/Supplemental Security Income (SSI) Statement

_____ Unemployment Benefit Letter

_____ Last 3 months bank statements

_____ Last 3 months pay stubs

_____ Self-attestation letter stating you, your spouse, or domestic partner, if applicable, are unemployed or self-employed

_____ Proof of any income received within the last 3 months (such as a pay stub or unemployment statement)

Once you complete this application and have gathered a copy of one of the above items, please return it to the address listed below. Please feel free to contact us if you have any questions or need assistance filling out the application at the number listed below.

Sincerely,

SummitStone Health Partners
Revenue Cycle Management – Billing Department
2451 S. Timberline Rd.
Fort Collins, CO 80525
(970) 494-9966

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SummitStone Health Partners Financial Assistance Application

Name of Client or Applicant _____

Name of Person Financially Responsible for Client or Applicant_____

Client or Applicant's SSN _____ Financially Responsible Person's SSN _____

Address _____
Street Apt # City State County Zip Code

Home Phone _____ Work Phone _____

Client or Applicant's Employer _____

Financially Responsible Person's Employer _____

List the names of family members who live in your household.

	Name	**Date of Birth**	**Social Security #**
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____

List any assets or resources you have:

Assets/Resources	Name	Value
Checking/Savings Accounts		$
Stocks, Bonds, CDs, Money Market Accounts		$
Other Assets (e.g., IRAs, 401K, cash, or assets readily convertible to cash, pensions, annuities, etc.) **Do not list your home(s) or vehicle(s).**		$

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List any income you receive:

Source	Frequency	Amount
		$
		$
		$
		$
Comments:		

Please initial:

_____ I confirm that information on the SummitStone Health Partners Financial Application is complete and accurate.

_____ I consent to allow SummitStone Health Partners to verify any information listed in this application.

_____ I understand that SummitStone Health Partners has a right to bill any payor source that I may be eligible for.

_____ _____

Individual Completing Application Signature Date

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OFFICIAL USE ONLY – DO NOT COMPLETE	
Client or Applicant's last three months GROSS income*: _____ _____ _____ **Person Financially Responsible last three months of GROSS income*:** _____ _____ _____ **Total Earned Income: *_____**	**Checklist** ☐ **Last 3 Months Pay Stubs** ☐ **Current Tax Return** ☐ **Unemployment Letter** ☐ **Social Security/SSDI/SSI Statement** ☐ **Insurance Card Copy, if Eligible** ☐ **Medicaid _____** ☐ **CICP _____** ☐ **MRN# _____** **Approval Signature/Date** _____

*Income from all sources, which includes current employment, unemployment, social security, SSDI, SSI, alimony, old age pension, pension plan, commissions, tips, child support, trust accounts, rental income interest, and any other income.