802 S 200 West
Suite A
Blanding, UT 84511
(435) 678-3993
info@bmhutah.org

Healthcare Assistance Application

Name:___________________________________SSN:__________________________Application Date:__________________
Mailing Address:____Home Phone:_______________
Employer Name/Address:____Work Phone:________________
Other Employers:____Cell Phone:________________

Reason For Application:____

List any Blue Mountain Hospital accounts and the amounts outstanding below. Note name if it is different from above:

Name on Account	Account #	Service Date	Amount	Name on Account	Account#	Service Date	Amount
				Total Of All Accounts			

Our philosophy on healthcare is to provide service regardless of ability to pay. However at the same time the hospital needs to maintain financial stability or it will be left unable to provide service. For this reason we ask all applicants to list what they can pay.

Partial payment is requested; please let us know what amount (interest free) you can pay each month. $______________

Do you have health insurance? Yes / No. If yes, please give the policy name and number:__________________________

Have you applied for Medicaid? Yes / No. If "yes", has your claim been denied? If "yes", please attach a copy of the denial with this application. If "no", are you willing to apply for Medicaid?____

The income information below needs to be verified by a copy of your most current tax return and checks stubs from the last three months. Please attach this information to the application (keep originals for your records),

Household gross annual income from tax return: $____________________Number of dependents in household:_____OR
Number of pay periods expected in the current year (if paid every two weeks, then 26 pay periods make up a year):_____
Household estimated gross annual income by annualizing the pay periods: $____
(Total of three months income divided by the number of checks times the number of pay periods expected in the year = estimated gross annual income)

Everything I have stated in the application is correct to the best of my knowledge. The Hospital is authorized to verify the information above.

Signed:____Date:_____________________________

Blue Mountain Hospital – Healthcare Assistance Program

List Assets:
Home (Property Tax Value) ____________________
Vehicle (Market Value) ____________________
Vehicle (Market Value) ____________________
Vehicle (Market Value) ____________________

Household Items:

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Other Assets:
Business (Market Value) ____________________
Farm (Market Value) ____________________
Livestock (Market Value) ____________________
Savings Accounts ____________________
Savings Accounts ____________________
Savings Accounts ____________________
Investments ____________________
Retirement ____________________
Other (Market Value) ____________________

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____

Total Assets ____________________

Monthly Income:
Job 1 ____________________
Job 2 ____________________
Job 3 ____________________
Job 4 ____________________
Social Security ____________________
Investment ____________________
Interest Income ____________________
Rents ____________________
Farm ____________________
Business ____________________
Other ____________________

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Total Income ____________________

List Liabilities:
Mortgage ____________________
Vehicle Loan ____________________
Vehicle Loan ____________________
Vehicle Loan ____________________

Credit Card Debt: ____________________

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Other Debt:
Business ____________________
Farm ____________________
Livestock ____________________
Other ____________________

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Total Liabilities ____________________

Monthly Expenses:
Mortgage/Rent ____________________
Vehicle Pymt ____________________
Vehicle Pymt ____________________
Vehicle Pymt ____________________
Credit Card Pymt ____________________
Other Loans ____________________
Groceries/Household ____________________
Utilities ____________________
Insurance ____________________
Vehicle Gas/oil other ____________________
Other ____________________

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Total Expenses ____________________