CASTLE ROCK
HOSPITAL DISTRICT

Financial Assistance Application
Determination of Eligibility

Guarantor Name ____Social Security No. ___________________________
Mailing Address ____Telephone No. ______________________________
Street Address ____City, State, Zip ______________________________
Patient Name(s) ____

Total Number of Persons in Your Household ______

Names ___________________________________ Age ______ Relationship* ___________________________
___________________________________ ______ ___________________________
___________________________________ ______ ___________________________
___________________________________ ______ ___________________________

*S=Spouse, C=Child, F=Friend, P=Parent

Income: Please Total and Provide Documentation of Your Gross Household Income

Household Income Last Three Months $______________________
Household Income Last Six Months $______________________
Household Income Last Twelve Months $______________________

Employment Record: Please List All Employment Held by All Members in Your Household for the Last Twelve Months

Employer Name _____________________________ Telephone No. ______________________________
Employer Name _____________________________ Telephone No. ______________________________
Employer Name _____________________________ Telephone No. ______________________________

Savings & Investments:

Please List all Investments, Checking & Savings Account Locations & Numbers
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Health & Accident Insurance

Does the Patient Have Health or Liability Insurance Coverage _____Yes _____No
If Yes, Please Complete the Insurance Information.
Insurance Carrier Name: _____________________________________Policy/Group No. _________________________
Carrier Address: ____City, State, Zip ___________________________
Subscriber Name: ____ Social Security No. _______________________

I give authorization to verify information with all financial institutions, creditors and any other party which might be able to provide financial information about the details of this application. I understand that the information I submit is subject to verification by Castle Rock Hospital District and subject to review. I certify that the above information is true, complete and correct.

Person(s) Making Request: ____Date ____________________

Business Office Use Only

This Document Was Received On _________________________By (Name) ____
Title ____

The Following Documents Were Provided to Verify Income and Family Composition:
Pay Check Stubs _________ Income Tax Form __________ Bank Statement _________ Other _________

Funding Recommendation: Approved _______________ Denied _______________ Date _______________
Reason for Approval or Denial: ____
By (Name) ____ Title _______________________________
Authorized by _________________________________ Title ___Business Office Manager_ Date ________
Authorized by _________________________________ Title _________________________ Date ________
Letter Sent On _________________________________ By (Name) ___________________ Date ________

Comments:
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