Dear Cheyenne Regional Medical Center Patient,

You are receiving this financial assistance application because you do not have health insurance, or you may not have health insurance that covers your hospital or clinical services received. Financial navigators will work with you to find a health insurance option that meets your health needs. Health insurance options include but are not limited to employer sponsored coverage, Medicaid, Medicare, Marketplace and COBRA. You may also be a candidate for disability benefits through the Social Security Administration. Prior to receiving financial assistance, you will need to enroll in the health insurance coverage option available to you and/or file a disability claim.

If your income is between 100% and 400% of the Federal Poverty Level, you may be eligible to receive cost assistance through the Health Insurance Marketplace (Marketplace) for your health insurance. If you are eligible for the Marketplace, you will be asked to apply for, enroll in, and pay your health insurance premium cost. Open Enrollment for the Marketplace is November 1, 2020 through December 15, 2020. If you meet the eligibility requirements for the Marketplace and enrollment is not open, navigators will speak with you to determine if you meet the requirements for a Special Enrollment Period (SEP). If you meet the requirement, you will be asked to apply and enroll. If ineligible for a Special Enrollment Period and you are approved for financial assistance, your financial assistance will end on or before October 31, 2020. You will then need to complete a Marketplace application for health insurance during Open Enrollment and pay your first month's premium to extend your financial assistance beyond this date.

If found eligible for employer sponsored health insurance coverage, your financial assistance will end one day prior to your open enrollment period with your employer. After submitting proof of enrollment, your financial assistance may be extended.

Sincerely,

Cheyenne Regional Medical Center Financial Navigation

I understand that I must apply for all eligible health insurance coverage and disability benefits as determined by a Financial Navigator prior to being eligible for financial assistance at Cheyenne Regional Medical Center. I understand that Cheyenne Regional Medical Center does not offer health insurance and can only provide financial assistance to help me pay my medical bills for a limited time period before I am asked to reapply.

____________________  ____________________  __________________
Patient Name          Patient Signature          Date

____________________  ____________________  __________________
Financial Navigator Name  Financial Navigator Signature  Date
Financial Assistance Application

Cheyenne Regional provides patient care regardless of ability to pay or insurance coverage status. You may be eligible to receive care at a reduced cost through our Financial Assistance program. This program is designed to assist individuals who cannot afford necessary healthcare and who are not eligible for health insurance programs.

Cheyenne Regional supports connecting patients to the care they need and continues to collaborate with other agencies with financial assistance programs within the Cheyenne community. Cheyenne Regional may be able to fully approve you for the Financial Assistance program with information provided to those agencies; however, there may be occasions that Cheyenne Regional will request additional information.

Complete one application per financial household including minor and adult children living in the household. Report income from all household members on this application.

To complete an application:

1. Provide Required Documentation Listed on Page 3.
   - All required documents must be provided within 30 days of receiving a complete application.

2. Complete the Application
   - Signatures are required on cover letter explaining policy, pages 6 and 8 and if applicable page 9.

Please schedule an appointment to return your completed application and documentation.

East Campus-Billing One-Stop            CRMC West Campus-Admissions
2600 E. 18th Street                     214 E. 23rd Street
Cheyenne, WY 82001                      Cheyenne, WY 82001
307-996-4777 Option 2                   307-996-4777 Option 2
Mon- Fri. 8:30am-5:00pm                  Mon-Fri 8:30am-5:00pm

**Appointments are available outside of normal business hours.**

For additional assistance in completing your application, please call 307-996-4777 (option 2) or e-mail us at Financial.assistance@crmcwy.org.

Please note, your email may not be secure. Although it is unlikely, there is a possibility that it can be intercepted and read by persons to whom the email is not addressed. Cheyenne Regional does not guarantee security or protection of personally identifiable information (PII) sent to its financial navigators via email. If you choose to email your application and/or supporting documents to Cheyenne Regional Financial Navigators, you assume the risk of any unauthorized access to your PII.
Required Documents:

- Photo Identification
  - Examples: Driver’s License, Passport, Student ID

- Proof of Residency
  - Examples: Utility bill with your name and address, rent receipt with name and address, proof of staying in a group home, shelter or residential treatment facility.

- Income Verification
  - In order to determine your level of financial assistance on a sliding scale, we must determine your income and family size. Please provide the following documentation:
    - Tax Return for the Most Current Filing Year OR a Non-Filing Tax Transcript. If you do not have a tax return for the most current filing year, you may request it at IRS.gov/transcript or call 800-908-9946. If you did not file taxes, please provide an IRS letter called the non-filing tax transcript stating that you did not file for the previous year. This may be requested on a 4506-T IRS document.
    - If your income is not accurately reflected on your tax return, please include income documentation for the last 90 days. Please see page three for a complete list of income that should be disclosed.
  - If you have no income, please complete the form on page 9 and provide the following documentation if they apply to you.
    - A copy of denied unemployment letter and copy of employment history from the Department of Workforce Services.
    - A letter verifying a recent stay at a shelter or other type of public facility.
    - A written statement from your physician documenting temporary disability.

- Private Health Insurance coverage card (including companies on the Health Insurance Marketplace and employer-based health insurance), Medicare A or B card, Medicare Supplemental Insurance, Medicaid or Equality Care.

Please note, Financial assistance is based upon the organization’s financial assistance policy. An approval for financial assistance with one provider does not guarantee an approval or a specific level of assistance at all locations.
Cheyenne Regional requires anyone applying for financial assistance to be screened for all health insurance coverage options prior to being approved for financial assistance. In order to determine if you or a member of your household may be eligible health insurance coverage, please complete the following section.

Please answer the following questions before proceeding to help determine your eligibility for public benefits or other health insurance coverage:

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
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<tbody>
<tr>
<td>☐</td>
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</table>

If it is determined that you or a family member is eligible for public assistance, coverage via the Marketplace or other insurance you must make every effort to enroll. Failure to cooperate with Cheyenne Regional in obtaining public benefits for the applicant or their family member will result in a denied financial assistance application.

**Income to Report on Application**

- Wages (as reported on the most current filing year tax return or 90 days of income verification if your income has recently changed)
- Social Security (Provide benefit letter)
- Unemployment (Provide benefit or denial letter)
- Worker’s Compensation Statement
- Completed Employer Statement Form
- Veteran’s Benefits
- Alimony
- Retirement Benefits/Pension
- Self-Employment
- Trust Fund Monies
- Rental Income
- Other Cash Income
- PELL Grants/Scholarships
### Client Information

**What Language do you speak?**  
- English  
- Spanish  
- Other  

---

**What Language do you write?**  
- English  
- Spanish  
- Other  

---

**Did someone complete this form on your behalf?**  
- Yes  
- No  

---

**Si usted prefiere este solicitud en español, por favor infórmenos.**

---

**Today's Date**  
**Social Security #:**  
**Gender/Identity**  
- M  
- F

---

**Last Name**  
**First Name, Middle Initial**  
**Date of Birth**  
**Sex**  
- M  
- F

---

**Other/Former/Maiden Names**  
**Are you a U.S. Citizen?**  
- Yes  
- No  

---

**Marital Status (Check one):**  
- Never Married  
- Married  
- Divorced  
- Legally Separated  
- Widowed  
- Minor Child

---

**Are you a veteran?**  
- No  
- Non-Combat  
- Combat

---

**Physical Address:**  
**City, State, Zip Code:**  
**County:**  
**Home Phone:**

---

**Mailing Address/P.O. Box**  
**City, State, Zip Code:**  
**County:**  
**Cell Phone:**

---

**Race (Check One):**  
- Asian  
- African American  
- American Indian/Alaska Native  
- Native Hawaiin/Pacific Islander  
- Other/Multi Racial  
- White  
- Decline to Answer  
- Unavailable

---

**Ethnicity (Check One):**  
- Non-Hispanic  
- Hispanic/Latino  
- Black  
- Unavailable  
- Decline to Answer

---

**Housing Information:**  
- Own  
- Rent  
- HUD/CHA  
- Homeless-How Long?  
- Group Home  
- Rent Free

---

**Highest Grade/Edu. Completed:**

---

**Employment (Check One):**  
- Full Time  
- Part Time  
- Self-Employed  
- Unemployed  
- Student  
- Disabled  
- Retired

---

**Employer Name:**  
**Employer Phone Number:**

---

**Employer Address:**  
**Date Hired:**

---

**Emergency Contact Name:**  
**Emergency Contact Number:**  
**Relationship to Patient:**

---

**Name of Parent/Guardian (For Dependents Only):**  
**Relationship to Patient:**

---

**Recently lost Employment? Date?**  
- Yes  
- No

---

**Family Size:**  
**Mother's First Name:**

---

**Did you have employer-based health coverage while employed?**  
- Yes  
- No

---

**If you are unemployed, have you filed for unemployment?**  
- Yes  
- No

---

**If you are unemployed, do you intend to go back to work?**  
- Yes  
- No

---

5 of 11
### Insurance Information

<table>
<thead>
<tr>
<th>Health Insurance:</th>
<th>Medicare:</th>
<th>Equality Care/Medicaid:</th>
<th>Kid Care CHIP:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Yes ☐ No</td>
<td>☐ Yes ☐ No</td>
<td>☐ Yes ☐ No</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>Policy #:</td>
<td>Policy #:</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Prescription Coverage:</th>
<th>Medicare Part D:</th>
<th>Prescription Coverage from Prescription Assistance Program (PDAP):</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Yes ☐ No</td>
<td>☐ Yes ☐ No</td>
<td>☐ Yes ☐ No</td>
</tr>
</tbody>
</table>

Are you enrolled in the Wyoming Medication Donation Program? ☐ Yes ☐ No

Do you have Social Security Disability? ☐ Yes ☐ No How long? _______________________

Prescription Coverage: ☐ Yes ☐ No

Medicare Part D: ☐ Yes ☐ No

Prescription Coverage from Prescription Assistance Program (PDAP): ☐ Yes ☐ No

Insurance Company:
COBRA ☐

Subscriber ID: Group ID:

Policy Holder Name:
Policy Holder Date of Birth: _____/_____/_____
Relationship to Patient:

Policy Holder Employer:
Employer Phone: (____) _____-_______
Policy Holder SSN:

Billing Claims Address: Customer Service Phone:
(____) _____-_______

Secondary Insurance Company: Subscriber ID: Group ID:
COBRA ☐

Policy Holder Name:
Policy Holder Date of Birth: _____/_____/_____
Relationship to Patient:

Policy Holder Employer:
Employer Phone: (____) _____-_______
Policy Holder SSN:

Billing Claims Address: Customer Service Phone:
(____) _____-_______

Are you seeking medical care as a result of an accident? ☐ Yes ☐ No If yes, complete the following:

Date of Accident: _____/_____/_____
Was it a motor vehicle accident? ☐ Yes ☐ No
Was the accident work related? ☐ Yes ☐ No

Where did the accident occur? Auto Insurance Company and Policy #: Worker's Compensation #:

Do you have an attorney involved and/or a settlement pending? ☐ Yes ☐ No

Assignment and Release: I authorize Cheyenne Regional Medical Center to disclose medical information as necessary to receive payment and assign all benefits, if any, directly to Cheyenne Regional Medical Center that otherwise might be payable to me for services rendered. I understand that Cheyenne Regional Medical Center may also release medical information about me to physicians or other health care providers who may be involved in my continued care. I understand that this authorization will remain in effect for twelve (12) months. If I choose to seek medical care with another provider, I understand that the treatment and information may still be shared with my insurance or other medical carrier. I understand that Cheyenne Regional Medical Center will file an initial claim with Medicare, Medicaid, insurance, or any other third party, if I have provided and signed the necessary information and/or forms. I understand that I am financially responsible for all of my charges whether or not they are covered by my insurance or other medical carrier. I also agree to be responsible for payment of any services rendered if my insurance company takes longer than sixty (60) days from the date of service. If this occurs, I will be responsible for seeking reimbursement from my insurance company. I authorize the use of this signature on all insurance submissions. I understand that if I fail to make a good faith effort to keep my account current, Cheyenne Regional Medical Center reserves the right to refuse non-acute medical services and to engage a collection agency for any outstanding balances.

Signature of Responsible Party: ___________________________ Date: ___________________________

Print Name: ___________________________ Relationship to Patient: ___________________________
## Household Members

Please list everyone living in your household including the applicant.

<table>
<thead>
<tr>
<th>Name: __________________________</th>
<th>Gender/Identity:</th>
<th>☐ M ☐ F</th>
<th>Sex:</th>
<th>☐ M ☐ F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationship to Applicant: ______</td>
<td>SSN: __________-<strong><strong><strong><strong>-</strong></strong></strong></strong></td>
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</tr>
<tr>
<td>Date of Birth: <strong><strong><strong>/</strong></strong><em>/</em></strong>_</td>
<td>What year was your last tax return filed? ______</td>
<td></td>
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</tr>
<tr>
<td>Can anyone claim you as a dependent on their tax return?</td>
<td>☐ Yes ☐ No</td>
<td></td>
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</tbody>
</table>

Do you have health insurance? ☐ Yes ☐ No

<table>
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<tr>
<th>Name of Insurance: __________________________</th>
<th>Policy #: _____________________________________</th>
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</table>

Please list all sources of Income (Gross Income/Month):

<table>
<thead>
<tr>
<th>Type: __________________________</th>
<th>Amount: $___________</th>
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</table>

Name: __________________________
Relationship to Applicant: __________________________
Date of Birth: ______/_____/____
Gender/Identity: | ☐ M ☐ F | Sex: | ☐ M ☐ F |
SSN: __________-________-________
What year was your last tax return filed? ______
Can anyone claim you as a dependent on their tax return? | ☐ Yes ☐ No |

Do you have health insurance? ☐ Yes ☐ No

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Relationship to Applicant: __________________________
Date of Birth: ______/_____/____
Gender/Identity: | ☐ M ☐ F | Sex: | ☐ M ☐ F |
SSN: __________-________-________
What year was your last tax return filed? ______
Can anyone claim you as a dependent on their tax return? | ☐ Yes ☐ No |

Do you have health insurance? ☐ Yes ☐ No

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Relationship to Applicant: __________________________
Date of Birth: ______/_____/____
Gender/Identity: | ☐ M ☐ F | Sex: | ☐ M ☐ F |
SSN: __________-________-________
What year was your last tax return filed? ______
Can anyone claim you as a dependent on their tax return? | ☐ Yes ☐ No |

Do you have health insurance? ☐ Yes ☐ No

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Name: __________________________
Relationship to Applicant: __________________________
Date of Birth: ______/_____/____
Gender/Identity: | ☐ M ☐ F | Sex: | ☐ M ☐ F |
SSN: __________-________-________
What year was your last tax return filed? ______
Can anyone claim you as a dependent on their tax return? | ☐ Yes ☐ No |

Do you have health insurance? ☐ Yes ☐ No

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</tbody>
</table>

Name: __________________________
Relationship to Applicant: __________________________
Date of Birth: ______/_____/____
Gender/Identity: | ☐ M ☐ F | Sex: | ☐ M ☐ F |
SSN: __________-________-________
What year was your last tax return filed? ______
Can anyone claim you as a dependent on their tax return? | ☐ Yes ☐ No |

Do you have health insurance? ☐ Yes ☐ No

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<td>Amount: $___________</td>
</tr>
<tr>
<td>Type: __________________________</td>
<td>Amount: $___________</td>
</tr>
</tbody>
</table>
IF NO INCOME IS INDICATED

If you have no income, please indicate which of the following you can provide as documentation:

- [ ] A copy of a denied unemployment letter.
- [ ] A letter from the Comea Shelter or Safe house verifying a recent stay at the shelter.
- [ ] Does anyone give you money on a monthly basis to pay your expenses?
  - [ ] Yes
  - [ ] No
  Amount of Monthly Payment Provided $___________
- [ ] Someone provides shelter and nutritional support for me. (Please complete the form on the following page 8.)

<table>
<thead>
<tr>
<th>May we provide you with information about payment arrangements?</th>
<th>[ ] Yes</th>
<th>[ ] No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you recently lost employment?</td>
<td>[ ] Yes</td>
<td>[ ] No</td>
</tr>
<tr>
<td>Are you eligible for COBRA benefits? Please list employer</td>
<td>[ ] Yes</td>
<td>[ ] No</td>
</tr>
<tr>
<td>__________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is your former employer contributing to you COBRA benefits?</td>
<td>[ ] Yes</td>
<td>[ ] No</td>
</tr>
<tr>
<td>Have you ever filed for Bankruptcy or do you intend to?</td>
<td>[ ] Yes</td>
<td>[ ] No</td>
</tr>
<tr>
<td>If yes, What state? ______ Case # ________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>File date: _______________ Discharge date: _______________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the reason for filing for bankruptcy due to medical bills? Yes or No</td>
<td>[ ] Yes</td>
<td>[ ] No</td>
</tr>
</tbody>
</table>

My signature indicates that all the information I have provided is true and correct. I hereby grant permission to this agency to obtain and share the information I have provided for the purpose of determining eligibility for assistance. I understand that failure to disclose insurance coverage for services provided or any household income will exclude me from receiving discounts and the agencies in which I applied for discounts have the right to full legal recourse to collect full billed charges.

Signature of Responsible Party _____________________________ Date _______________

Print Name ____________________________ Relationship to Patient _______________
**Statement of Self-Declared Income**

**A. Patient**

Please list yourself and the persons in your household. (A household is defined as yourself, spouse, and dependents.)

<p>| | | |</p>
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</table>

*******WHENEVER THERE IS A CHANGE IN THESE CIRCUMSTANCES, ANOTHER FORM MUST BE COMPLETED*******

Have you ever filed a tax return? YES NO
If yes, what was the year of the last time you filed?

STOP HERE! The rest of this form is to be completed by the person you are either living with or your employer.

Please answer the questions in section B, section C, section D, and section E as appropriate in regards to those listed above.

Please print your name:______________________________________________________

**B. Shelter/Nutritional Support**

1. I pay for or furnish shelter for the individuals listed at the top of the page. YES NO
   a. If YES, list the address of the shelter or housing provider:
   
   __________________________________________________

2. I provide food for the individuals listed at the top of the page. YES NO
   a. If NO, how is food purchased for the individuals listed at the top of the page?

   Food Stamps  Donated Food  Other: ______________________________________________________

3. Is the person listed above paying rent or utilities? YES NO
   a. If YES, how much do they pay for rent and/or utilities on a monthly basis?

********WHENEVER THERE IS A CHANGE IN THESE CIRCUMSTANCES, ANOTHER FORM MUST BE COMPLETED*******

**C. Unemployment**

1. To the best of my knowledge, the individuals listed above are not employed: YES NO
   a. If NO, who is employed?

   Place of employment?

**D. Verification of Employment**

1. I employ the following person(s) listed above: __________________________________________________

2. I give a monthly wage of $____________________ to the employed individuals.

**E. Cash Contributions**

I give monthly cash contributions to the person(s) listed above in the amount of $____________________.

I declare under penalty of perjury, that all statements on this form are true to the best of my knowledge.

<table>
<thead>
<tr>
<th>Signature of person completing this form</th>
</tr>
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<tbody>
<tr>
<td>/</td>
</tr>
<tr>
<td>Print Name</td>
</tr>
<tr>
<td>Date</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Signature of Patient (or responsible party of minor)</th>
</tr>
</thead>
<tbody>
<tr>
<td>/</td>
</tr>
<tr>
<td>Print Name</td>
</tr>
<tr>
<td>Date</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address of person completing the form</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Did we get a copy of or verify the signer’s ID:</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES  NO</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Phone Number of person completing the form</th>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Relationship to Patient</th>
</tr>
</thead>
</table>

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DISABILITY CLAIM SCREENING FORM (complete only if you marked disabled and need to file)

If you are currently physically or mentally disabled or expect to be within the next 12 months and would like to file for disability, please complete the form below and review with a Financial Navigator during your financial assistance intake appointment.

Name of Individual in Household that is physically or mentally disabled: _______________________

Part A: Homelessness/At-Risk Assessment

Where are you currently living? Check the appropriate selection.

<table>
<thead>
<tr>
<th>Homeless</th>
<th>At-Risk for Homelessness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outdoors</td>
<td>Doubled up/couch-surfare</td>
</tr>
<tr>
<td>Shelter</td>
<td>Received eviction notice or owe substantial payments in rent/utilities</td>
</tr>
<tr>
<td>Transitional Housing</td>
<td>Permanent supportive housing that is grant funded (Housing First placements)</td>
</tr>
</tbody>
</table>

If homeless, how long have you been homeless: ________Years and _____ Months

Are you in an institution or jail? □ Yes □ No

  If yes, are you expected to be released within 30 days? □ Yes □ No

  Were you experiencing homelessness before entering the facility? □ Yes □ No

Have you had difficulty maintaining housing? □ Yes □ No

If yes, please describe: ____________________________________________________________

_____________________________________________________________________________
DISABILITY CLAIM SCREENING FORM CONTINUED

Part B: Current Application for SSA Benefits or Pending Appeal

Have you recently applied for Social Security benefits? □ Yes □ No
If yes, date:___________ Decision on application: □ Pending □ Denied □ Pending Appeal
If pending appeal, are you waiting on a decision? □ Yes □ No
Are you working with a lawyer? □ Yes □ No

Part C: Diagnostic Information

Please list all of your mental and physical health diagnoses:

Where have you been treated for these conditions? Please provide the name(s) of your doctor(s).

Current medications and prescribing care provider/agency:

Do you have a history of substance use? □ Yes □ No

Last substance(s) used: Last known date of use: