



## 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 public benefit programs.

Cheyenne Regional supports the GoalConnect initiative. GoalConnect is a tool that allows various agencies within the Cheyenne community to share information that you provide on Financial Assistance Applications. Cheyenne Regional may be able to fully approve you for the Financial Assistance program with information provided to participating agencies; however, there may be occasions that Cheyenne Regional will request additional information.

Complete one application per 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 2.
  - **All required documents must be provided within 30 days of the initial appointment.**
2. Complete the Application
  - **Signatures are required on pages 5, 7, 8 and 9 (if applicable), 11**

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

East Campus-Billing One-Stop  
2600 E. 18<sup>th</sup> Street  
Cheyenne, WY 82001  
307-996-4777 Option 2  
Mon- Fri. 7:00am-4:30pm

CRMC West Campus  
214 E. 23<sup>rd</sup> Street  
Cheyenne, WY 82001  
307-996-4777 Option 2  
Mon-Fri 8:00am-4:30pm

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

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



## 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:
    - Most Recent Tax Return
    - If you do not have your most recent tax return, you may request it at **IRS.gov/transcript** or call **800-908-9946**. If you did not file taxes, please provide an IRS letter stating that you did not file for the previous year.
    - 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 copy of the letter from the Department of Family Services that shows eligibility for the Wyoming SNAP program.
    - 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 Insurance coverage card, Medicare A or B card, Medicare Part D care, 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 public benefits and private insurance through the Marketplace prior to being approved for financial assistance. In order to determine if you or a member of your household may be eligible for public benefits or other 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:**

- | Yes                      | No                       |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <i>Is anyone in the household pregnant?</i>  |
| <input type="checkbox"/> | <input type="checkbox"/> | <i>Has anyone in the household miscarried in the last 90 days?</i>   |
| <input type="checkbox"/> | <input type="checkbox"/> | <i>Is anyone in the household under 19 years old?</i>  |
| <input type="checkbox"/> | <input type="checkbox"/> | <i>Is anyone in the household currently physically or mentally disabled or expected to be in the next 12 months?</i> |
| <input type="checkbox"/> | <input type="checkbox"/> | <i>Did you lose health insurance coverage within the past 60 days?</i>   |
| <input type="checkbox"/> | <input type="checkbox"/> | <i>Have you had an increase in income?</i>   |
| <input type="checkbox"/> | <input type="checkbox"/> | <i>Have you previously received financial assistance at CRMC? When? _____</i>  |

**If it is determined that you or a family member is eligible for public assistance or coverage via the Marketplace, 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 your most recent 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
- Certificate of Credible Coverage loss from previous health insurance provider



**Client Information**

What Language do you speak?	<input type="checkbox"/> English	<input type="checkbox"/> Spanish	<input type="checkbox"/> Other	_____
What Language do you write	<input type="checkbox"/> English	<input type="checkbox"/> Spanish	<input type="checkbox"/> Other	_____
Did someone complete this form on your behalf?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		

Si usted prefería 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 <input type="checkbox"/> M <input type="checkbox"/> F
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Other/Former/Maiden Names	Are you a U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No	Marital Status (Check one): <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Minor Child
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Are you a veteran? <input type="checkbox"/> No <input type="checkbox"/> Non-Combat <input type="checkbox"/> Combat	E-Mail Address:
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Physical Address:	City, State, Zip Code:	County:	Home Phone:
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Mailing Address/P.O. Box	City, State, Zip Code:	County:	Cell Phone:
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Race (Check One): <input type="checkbox"/> Asian <input type="checkbox"/> African American <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Native Hawaiiin/Pacific Islander <input type="checkbox"/> Other/Multi Racial <input type="checkbox"/> White <input type="checkbox"/> Decline to Answer <input type="checkbox"/> Unavailable	Work Phone:
	Message Phone:

Ethnicity(Check One): <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Black <input type="checkbox"/> Unavailable <input type="checkbox"/> Decline to Answer	Housing Information: <input type="checkbox"/> Own <input type="checkbox"/> Rent <input type="checkbox"/> HUD/CHA <input type="checkbox"/> Homeless <input type="checkbox"/> Rent Free <input type="checkbox"/> Group Home	Highest Grade/Edu. Completed:
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Employment (Check one): <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Self-Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Student <input type="checkbox"/> Disabled <input type="checkbox"/> Retired	Employer Name:	Employer Phone Number:
	Employer Address:	Date Hired:

Emergency Contact Name:	Emergency Contact Number:	Relationship to Patient:
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Name of Parent/Guardian (For Dependents Only):	Relationship to Patient:
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Recently lost Employment? Date? <input type="checkbox"/> Yes <input type="checkbox"/> No	Family Size:	Mother's First Name:
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Did you have employer-based health coverage while employed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Place of Birth (City, County, State):
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If you are unemployed, have you filed for unemployment? Please provide approval or denial letter	<input type="checkbox"/> Yes <input type="checkbox"/> No
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If you are unemployed, do you intend to go back to work? If yes, when? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Insurance Information			
Health Insurance: <input type="checkbox"/> Yes <input type="checkbox"/> No	Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No Policy #:	Equality Care/Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No Policy #:	Kid Care CHIP: <input type="checkbox"/> Yes <input type="checkbox"/> No Policy #:
Prescription Coverage: <input type="checkbox"/> Yes <input type="checkbox"/> No	Medicare Part D: <input type="checkbox"/> Yes <input type="checkbox"/> No	Prescription Coverage from Prescription Assistance Program (PDAP)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you enrolled in the Wyoming Medication Donation Program? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If unemployed, Are you eligible for COBRA benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Do you have Social Security Disability? <input type="checkbox"/> Yes <input type="checkbox"/> No How long? _____			
Insurance Company: COBRA <input type="checkbox"/>	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: COBRA <input type="checkbox"/>	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: (____) ____-____	
<b>Are you seeking medical care as a result of an accident?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If yes, complete the following:</b>			
Date of Accident: ____/____/____	Was it a motor vehicle accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	Was the accident work related? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>Assignment and Release:</b> 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 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: \_\_\_\_\_



<b>Household Members</b>	
Please list everyone living in your household including the applicant.	
Name: _____ Relationship to Applicant: _____ Date of Birth: ____/____/____ Do you have health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No Name of Insurance: _____ Policy #: _____	Gender/Identity: <input type="checkbox"/> M <input type="checkbox"/> F      Sex: <input type="checkbox"/> M <input type="checkbox"/> F SSN: _____-_____-_____ What year was your last tax return filed? _____ Can anyone claim you as a dependent on their tax return? <input type="checkbox"/> Yes <input type="checkbox"/> No Please list all sources of Income (Gross Income/Month): Type: _____ Amount: \$ _____ Type: _____ Amount: \$ _____ Type: _____ Amount: \$ _____ Type: _____ Amount: \$ _____
Name: _____ Relationship to Applicant: _____ Date of Birth: ____/____/____ Do you have health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No Name of Insurance: _____ Policy #: _____	Gender/Identity: <input type="checkbox"/> M <input type="checkbox"/> F      Sex: <input type="checkbox"/> M <input type="checkbox"/> F SSN: _____-_____-_____ What year was your last tax return filed? _____ Can anyone claim you as a dependent on their tax return? <input type="checkbox"/> Yes <input type="checkbox"/> No Please list all sources of Income (Gross Income/Month): Type: _____ Amount: \$ _____ Type: _____ Amount: \$ _____ Type: _____ Amount: \$ _____ Type: _____ Amount: \$ _____
Name: _____ Relationship to Applicant: _____ Date of Birth: ____/____/____ Do you have health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No Name of Insurance: _____ Policy #: _____	Gender/Identity: <input type="checkbox"/> M <input type="checkbox"/> F      Sex: <input type="checkbox"/> M <input type="checkbox"/> F SSN: _____-_____-_____ What year was your last tax return filed? _____ Can anyone claim you as a dependent on their tax return? <input type="checkbox"/> Yes <input type="checkbox"/> No Please list all sources of Income (Gross Income/Month): Type: _____ Amount: \$ _____ Type: _____ Amount: \$ _____ Type: _____ Amount: \$ _____ Type: _____ Amount: \$ _____
Name: _____ Relationship to Applicant: _____ Date of Birth: ____/____/____ Do you have health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No Name of Insurance: _____ Policy #: _____	Gender/Identity: <input type="checkbox"/> M <input type="checkbox"/> F      Sex: <input type="checkbox"/> M <input type="checkbox"/> F SSN: _____-_____-_____ What year was your last tax return filed? _____ Can anyone claim you as a dependent on their tax return? <input type="checkbox"/> Yes <input type="checkbox"/> No Please list all sources of Income (Gross Income/Month): Type: _____ Amount: \$ _____ Type: _____ Amount: \$ _____ Type: _____ Amount: \$ _____ Type: _____ Amount: \$ _____



Financial Assistance Application (Continued)

IF NO INCOME IS INDICATED

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

- Checkboxes for documentation options: denied unemployment letter, SNAP program, shelter stay, monthly expenses, and nutritional support.

Table with 3 columns: Question, Yes, No. Rows include questions about payment arrangements, employment loss, COBRA benefits, bankruptcy, and medical bills.

My signature indicates that all of 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.

Signature of Responsible Party \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Agency Representative: \_\_\_\_\_ Date \_\_\_\_\_

**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.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

Have you ever filed a tax return? \_\_\_\_\_ If yes, what was the date 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, or 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 \_\_\_\_\_
  - b. If NO, who pays for or furnishes shelter for the individuals listed at the top of the page:  
\_\_\_\_\_
- 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? \_\_\_\_\_

**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.**

\_\_\_\_\_  
Signature of person completing this form      Signature of Patient (or responsible party of minor)

\_\_\_\_\_/\_\_\_\_\_  
Print Name      Date      Print Name      Date

\_\_\_\_\_  
Address of person completing the form

\_\_\_\_\_  
Phone Number of person completing the form      Did we get a copy of or verify the signer's ID:      YES      NO

\_\_\_\_\_  
Relationship to Patient





## Summary

In order to serve you better, Cheyenne Regional participates in the Laramie County GoalConnect Collaborative. GoalConnect is linking multiple agencies together to better serve clients, reduce duplication efforts and decrease gaps in access to the most needed services.

### **Purpose and Benefits to your Care**

Goal Connect partners want to better serve your needs through coordinating services. Sharing your individual information may reduce the need for a referral or connect you to public programs and community service groups that may help you. It may tell providers about your health history, allergies and prescription drugs to coordinate your care. Finally, being in the system can reduce repeated paperwork.

### **You Choose to Participate**

We ask you to sign this form to include you in the goal connect system. It is your choice to sign. No provider may refuse to treat you if you do not sign. If you do not sign the form, providers will not share your information through the database. You may cancel your authorization at any time.

### **Security and Privacy Information**

Federal and state laws protect the privacy of your information. GoalConnect protects your information by strictly limiting who can access the system. We require all participating partners, their employees, agents, and business associates to sign confidentiality agreements to maintain the security of your information. You will receive the HIPAA notice of Privacy Practices, which gives you the additional information about the provider's respective confidentiality policies.

### **Current Participating partners of GoalConnect are:**

- Cheyenne Regional Medical Center
- HealthWorks
- Peak Wellness Center, Inc.
- Needs, Inc.
- Comea
- Wyoming Interfaith Health Ministries (Faith Nurses)
- Community Action of Laramie County - Healthcare for Homeless
- Community Action of Laramie County - Kinship Support Services
- University of Wyoming Family Practice
- Family Promise of Cheyenne

**\*\* Financial assistance is based upon the individual organization's financial assistance policy. An approval for financial assistance with one organization does not guarantee an approval or a specific level of assistance at all location.**



### Consent Form

- I understand by signing this form, I give permission for my provider, a Goal Connect Participating Partner, to enter my individually identifiable information in the GoalConnect system.
- I understand that my individual information could include participating in an Agency program, demographic information to include name, birth date, gender, race, social security number, address, phone number, household members, financial information, employment status, residential information health and treatment history and/or personal or family information.
- I have reviewed the list of current GoalConnect partners, and I know that others may be added later. A list of partners is available to me upon my request.
- I have received a copy of this form.
- I understand that this form will be effective unless I cancel it or GoalConnect ends. I can cancel this authorization at any time by completing a cancellation form, which I can get from any participating provider.
- I understand if I sign on behalf of someone else, I am certifying that I have authority under Wyoming law to make health care and social services decisions for that person.
- I understand I am allowing GoalConnect to share my individual identifiable information and that no partner may access my information unless I go to that participating provider for services.
- I understand that this is my choice to sign and that no provider may refuse to treat me if I do not sign.

**I have read and understand the above information.**

\_\_\_\_\_  
Your Name (Print)

\_\_\_\_\_  
Authorized Representative Relationship to Patient

\_\_\_\_\_  
Your Signature (or Representative)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Facility

\_\_\_\_\_  
Client DOB

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date