Cheyenne Regional

Dear Cheyenne Regional 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 services received at Cheyenne Regional Medical Center or clinical services received through Cheyenne Regional Medical Group. 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. The service area for financial assistance is Laramie County. 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 at least 100% 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, 2022 through December 15, 2022. 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, 2022. 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.

Please note that patient responsibility due to copays, coinsurance, and/or deductibles are not eligible for financial assistance discounts.

Sincerely,

Cheyenne Regional 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. I understand that Cheyenne Regional <u>does not</u> 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. I understand that the service area is Laramie County and that I will not receive a discount on the out-of-pocket costs I am responsible for as a result of copays, coinsurance, and/or deductibles for my health insurance plan.

_____	_____	_____
Patient Name	Patient Signature	Date
_____	_____	_____
Financial Navigator Name	Financial Navigator Signature	Date

Revised 1/18/2022

Cheyenne Regional

Financial Assistance Application

Cheyenne Regional provides patient care regardless of ability to pay or insurance coverage status. Financial Assistance applies to Cheyenne Regional Medical Center and Cheyenne Regional Medical Group. 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. Effective April 1, 2020, financial assistance discounts are not applied to patient responsibility for out-of-pocket costs as a result of copays, coinsurances, and/or deductibles.

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 7 and 8 and if applicable page 9 and page 13.**

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

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

CRMC West Campus-Admissions
214 E. 23rd Street
Cheyenne, WY 82001
307-996-4777 Option 2
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, family size, and other financial resources available to you. Please see page four for a complete list of income and/or resources that should be disclosed. Please provide the following documentation:
    - Bank Statements: Provide 90 days of bank statements for ALL accounts (checking, savings, or other) from all banks for all financial household members.
    - Tax Return for the Most Current Filing Year OR a Non-Filing Tax Transcript if you do not file taxes.
      - 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.**
    - No Income Verification: 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 or long-term 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.

Prior to financial assistance eligibility determination, a financial navigator will speak with you. At this time, additional documents may be requested.

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

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:

Yes	No	
☐	☐	*Is anyone in the household pregnant?*
☐	☐	*Has anyone in the household miscarried in the last 90 days?*
☐	☐	*Is anyone in the household under 19 years old?*
☐	☐	*Is anyone in the household currently or expected to be physically or mentally disabled for the next 12 months?*
		If yes and you have not filed for disability and are not receiving disability payments, complete pages 10-11.
☐	☐	*Did you lose health insurance coverage within the past 60 days? If yes, what date?* _____
☐	☐	*Have you had an increase in income?*
☐	☐	*Have you previously received financial assistance at CRMC? When?*_____

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.

<u>Income to Report on Application</u>

- 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

Cheyenne Regional

Guarantor 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 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 ☐ M ☐ F

Other/Former/Maiden Names:	Are you a U.S. Citizen? ☐Yes ☐o		Marital Status (Check one): ☐Never Married ☐Married ☐Divorced ☐Legally Separated ☐Widowed ☐Minor Child
Are you a veteran? ☐ No ☐Non-Combat ☐Combat	E-Mail Address:		
Physical Address:	City, State, Zip Code:	County:	Home Phone:
Mailing Address/P.O. Box	City, State, Zip Code:	County:	Cell Phone: Text Message: Yes or No
Race (Check One): ☐ Asian ☐African American ☐American Indian/Alaska Native ☐ Native Hawaiin/Pacific Islander ☐Other/Multi Racial ☐ White ☐Decline to Answer ☐Unavailable			Message Phone:
Ethnicity(Check One): ☐ Non-Hispanic ☐Hispanic/Latino ☐ African American ☐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:
Last Year Taxes Filed?		Can someone claim you as a dependent?	
Recently lost Employment? Date? ☐ Yes ☐ No	Date Last Worked:		Financial Household Size:
Did you have employer-based health coverage while employed? ☐ Yes ☐ No		Place of Birth (City, County, State):	
If you are unemployed, have you filed for unemployment? Please provide approval or denial letter			☐ Yes ☐ No
If you are unemployed, do you intend to go back to work? If yes, when? _____			☐ Yes ☐ No

Additional Financial Household Members

Please list the other financial household members.

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 Name of Insurance: ________________________ Policy #: ________________________________	Please list all sources of Income (Gross Income/Month): Type: _______________________ Amount: $_________ Type: _______________________ Amount: $_________ Type: _______________________ Amount: $_________ Type: _______________________ Amount: $_________
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 Name of Insurance: ________________________ Policy #: ________________________________	Please list all sources of Income (Gross Income/Month): Type: _______________________ Amount: $_________ Type: _______________________ Amount: $_________ Type: _______________________ Amount: $_________ Type: _______________________ Amount: $_________
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 Name of Insurance: ________________________ Policy #: ________________________________	Please list all sources of Income (Gross Income/Month): Type: _______________________ Amount: $_________ Type: _______________________ Amount: $_________ Type: _______________________ Amount: $_________ Type: _______________________ Amount: $_________
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 Name of Insurance: ________________________ Policy #: ________________________________	Please list all sources of Income (Gross Income/Month): Type: _______________________ Amount: $_________ Type: _______________________ Amount: $_________ Type: _______________________ Amount: $_________ Type: _______________________ Amount: $_________

Cheyenne Regional

Insurance Information

Health Insurance: ☐ Yes ☐ No	Medicare: ☐ Yes ☐ No Policy #:	Equality Care/Medicaid: ☐ Yes ☐ No Policy #:	Kid Care CHIP: ☐ Yes ☐ No Policy #:
Prescription Coverage: ☐ Yes ☐ No	Medicare Part D: ☐ Yes ☐ No	Prescription Coverage from Prescription Assistance Program (PDAP)? ☐ Yes ☐ No	
Are you enrolled in the Wyoming Medication Donation Program? ☐ Yes ☐ No			
If unemployed, Are you eligible for COBRA benefits? ☐ Yes ☐ No			
Do you have Social Security Disability? ☐Yes ☐No How long? _____			
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: 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: (_____) _____-_____
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 to disclose medical information as necessary to receive payment and assign all benefits, if any, directly to Cheyenne Regional that otherwise might be payable to me for services rendered. I understand that Cheyenne Regional 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 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 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:**_____

PATIENTS WITHOUT INCOME

If you have no income, please indicate which of the following you can provide as documentation (select all that apply):

☐ 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 9.)**

ALL PATIENTS: COBRA INSURANCE AND BILLING QUESTIONS

May we provide you with information about payment arrangements?	☐ Yes	☐ No
Have you recently lost employment? If you lost employment in the past 60 days and had health insurance coverage, are you eligible for COBRA benefits? Please list employer _____ Is your former employer contributing to you COBRA benefits?	☐ Yes ☐ Yes ☐ Yes	☐ No ☐ No ☐ N/A ☐ No
Have you ever filed for Bankruptcy or do you intend to? If yes, What state? _____ Case # _____ File date: _____ Discharge date: _____ Is the reason for filing for bankruptcy due to medical bills?	☐ Yes ☐ Yes	☐ No ☐ No

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 _____

Cheyenne Regional

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 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: _____
   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 Constibutions

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

_____ Did we get a copy of or verify the signer's ID: **YES** **NO**

Phone Number of person completing the form

_____

Relationship to Patient

Cheyenne Regional

DISABILITY CLAIM SCREENING FORM

Complete this form if you have a disability and have not submitted a claim to the Social Security Administration.

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.*

Homeless	
Outdoors	☐
Shelter	☐
Transitional Housing	☐

At-Risk for Homelessness	
Doubled up/couch-surfing	☐
Received eviction notice or owe substantial payments in rent/utilities	☐
Permanent supportive housing that is grant funded (Housing First placements)	☐
Exiting foster care	☐
Institution – hospital, nursing home, etc.	☐
Jail	☐

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

Complete this form if you have a disability and have not submitted a claim to the Social Security Administration.

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:

Cheyenne Regional

Community Connect Summary

In order to serve you better, Cheyenne Regional participated in the Laramie County Goal Connect Collaborative. Goal Connect linked multiple agencies together to better serve clients, reduce duplication efforts and decrease gaps in access to the most needed services. Although the Goal Connect database is no longer active, Financial Navigators may continue to share your information with community partners upon your request to assist with your application and eligibility process throughout the community for other assistance programs.

Purpose and Benefits to your Care

We 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. Participating can also reduce repeated paperwork.

You Choose to Participate

We ask you to sign this form which allows Cheyenne Regional Financial Navigators to share your financial assistance application packet with community partners with whom Cheyenne Regional collaborates. 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, Financial Navigators will not share your information. You may cancel your authorization at any time. Cheyenne Regional Financial Navigators do not receive any reimbursement, incentive, referral fees or any other type of monetary, reward, tangible or intangible benefits for such referral.

Security and Privacy Information

Federal and state laws protect the privacy of your information. Financial Navigators will share information via fax upon your request. Financial Navigators comply with HIPAA privacy practices. You will receive the HIPAA notice of Privacy Practices, which gives you the additional information about the provider's respective confidentiality policies.

Current Collaborating Partners are:

- Cheyenne Regional
- HealthWorks
- Peak Wellness Center, Inc.
- Needs, Inc.
- COMEA Shelter
- Community Action of Laramie County - Healthcare for Homeless
- Community Action of Laramie County - Kinship Support Services
- University of Wyoming Family Practice

*** 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 locations.*

Community Connect Consent Form (Optional)

- I understand by signing this form, I give permission for a Cheyenne Regional Financial Navigator to share my individually identifiable information with community partners with whom they collaborate.
- 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 collaborating 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. I can cancel this authorization at any time by providing a written request.
- 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 a Financial Navigator to share my individual identifiable information with only the collaborating partner(s) listed that I go to 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) Relationship to Patient

_____ _____

Your Signature (or Representative) Date

_____ _____

Financial Navigator Date