San Luis Valley
HEALTH

Rev.4/21/2106

**SLV Health Charity Care Program Application** SLV Health VISIT ID #____________

**It is the policy of San Luis Valley Health to provide essential services regardless of the patient's ability to pay. Discounts are offered based upon family/household size and annual income.**

**One application per household.**

**Services from other providers such as outside providers, pathologists, and radiologists are not included in SLVH's charges or discounts.**

**This is not considered insurance and cannot be used in conjunction with any other health insurance.**

**This form must be completed every 12 months or if your financial situation changes.**

**Please complete the following information and return to a Financial Counselor to determine if you or members of your family are eligible for financial assistance.**

Number of related persons in your taxable household: ______

| Household Member | Household Income (**complete one column**) | | |
|---|---|---|---|
| | Annual | Monthly | Bi-Weekly |
| Self | | | |
| Spouse | | | |
| Other | | | |
| TOTAL | | | |

I certify that the family size and income information shown above is correct. Copies of tax returns, pay stubs, or other information verifying income is required before a discount is approved.

____________________________ __________________________ ___________ _____

Print Patient Name Patient Signature DOB Date

List all names and DOBS of each member of the household:

| Name | Date of Birth | Other Insurance |
|---|---|---|
| __________________________ | _______________ | __________________________ |
| __________________________ | _______________ | __________________________ |
| __________________________ | _______________ | __________________________ |
| __________________________ | _______________ | __________________________ |