Valor Health
Our priority is people

1202 E Locust St., Emmett, ID 83617
(208) 365-3561 | valorhealth.org

Thank you for your interest in our Financial Assistance Program. If you and/or a family member who currently resides with you has applied for financial assistance at Valor Health within the last six months, please contact our office at 208-365-3561 before completing this application.

With your completed application, we **require** that you include the following documents to assist us with the processing of your application:

- Three months income for all household members currently employed. Example: pay stubs, W2, disability, pension, unemployment, workman's comp, etc. (**Required**)
- Three months of bank statements for all accounts (checking/savings) owned by patient and/or spouse (**Required**)
- Most recent income tax return (**Required**, if filed)
- A letter from clergy/family/friends/etc. if you are supported financially by these sources.

If for any reason you cannot provide us with all the required documents, you must provide a written letter providing an explanation as to why. All information given to the Patient Financial Counselor is held in the strictest confidentiality.

Please submit application and all supporting documentation within 30 days of receipt of application. If all information is not returned in the allotted time, your application will be voided, and you will need to start the application process over. You will only be notified one time by mail if you are missing any information that prevents us from processing your application.

Please allow approximately 30 days for processing once we have received a complete application. If you have any questions or need assistance completing your application, please feel free to contact our office at the number listed below.

Thank you for choosing Valor Health!

Sincerely,

Valor Health
Patient Financial Services
208-365-3561

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Financial Assistance Application

Patient's Name:		Date of Birth:
Street Address:	Phone Number (Home):	Phone Number (Cell):
City/State/Zip:	Social Security Number:	
Mailing Address (if different than street address):		

Please provide the following information for all household members:

Name (if not patient):	SSN:	Date of Birth:	Relationship to Patient:

Please List all accounts and/or date(s) of service to be considered for Financial Assistance (attach another pg. if needed):

Patient's Name:	Account #:	Date of Service:	Balance:

Have you applied for insurance?	o Yes	o No	If yes, what is the name and policy number:

Monetary Assets

Checking Account Balance:	Bank Name:
Savings Account Balance:	Bank Name:

Employment

Person Employed (including patient/Self Employed):	Employer:	Gross Monthly Income:	# of Pay Periods in a month	Annual Gross Income:

Other Sources of Income	**Monthly**	**Annually**
Alimony	$	$
Public Assistance Program Type_____ (e.g., cash, food stamps, etc.)	$	$
Payment from Retirement Plan	$	$
Social Security/Disability	$	$
Unemployment or Workman's Compensation (Start Date:_____ End Date:_____) # of Weeks:_____ $ Per Week:	$	$
Other Income (Stocks, Bonds, Annuities, Rentals, Interest):	$	$
Other Income (Family, church, friends, etc.)	$	$

Please provide any other additional information to be considered for financial assistance with Valor Health. (ex: excessive medical bills, letters from family/clergy/friends stating how living expenses are being met, lapses in insurance, getting laid off, etc.): _____

_____

_____

I certify that all information provided is true and complete to the best of my knowledge. I understand that I must provide verification of income, bank statements, tax returns, and other supporting documentation and failure to provide this information may result in my financial assistance application being denied. I also understand that I will be liable for payment of any services rendered at Valor Health if the above information is given under false pretenses. I understand that this application is valid only for services provided at Valor Health.

Signature of Applicant: _____ Date: _____

Spouse Signature (if applicable): _____ Date: _____