# SLV Health Charity Care Application

**SLV HEALTH VISIT ID or MRN #** _____ **DATE OF APPLICATION** _____

_____ _____

Name of person applying Address

Number of related persons in your taxable household: _____

Please list the names, dates of birth, other insurance information, and income for the members of your household below, include yourself.

| NAME | DOB | OTHER INSURANCE (Y/N) | NAME OF OTHER INSURANCE | INCOME BEFORE TAXES | PAY PERIOD TYPE (ANNUAL, MONTHLY, BI-WEEKLY) |
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| | | | | Total | |

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Signature of person applying

By signing this application, 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 discount is approved.

**Disclaimer: It is the policy of San Luis Valley Health to provide essential services regardless of 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.**