Northern Cochise Community Hospital, Inc.
Financial Assistance Program

Information Page

Northern Cochise Community Hospital, Inc offers financial assistance for medical care to eligible patients. Our financial assistance program includes discounted services or relief of debt incurred at NCCH Inc.

You may be eligible for financial assistance if you:

- Are a resident of Arizona
- Are not eligible with AHCCCS
- Are uninsured and/or have limited health coverage
- Can show financial hardship
- Can provide necessary information and documents about your household finances

Application Process:

- Complete the Financial Assistance Application
  - Includes supporting documents
- Go over Financial Assistance Application with Financial Counselor
- Completed Application is submitted to Patient Financial Services Director to be approved or denied and following to CEO or CFO to be approved or denied
- We contact you via phone and by mail
- If your case has a remaining balance, we will setup a payment agreement

*NOTE: this program is for Northern Cochise Community Hospital Inc. charges **only***

Filing Your Application

If you are unable to present your application in person, please mail your completed application form and copies of your documents to:

Northern Cochise Community Hospital Inc.
901 W Rex Allen Dr
Willcox, AZ 85643
ATTN: Patient Financial Services

*If you have any questions, please call **520-384-3541 ext. 6451***

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Documentation Checklist

Your application must include copies of any of the following documents that apply to you. Please attach copies, not originals. If any of the required documents are missing, it will delay processing of your application.

1. **Income**
   - ☐ If you have income, attach a copy of your most recent filed tax forms
   - ☐ If you or anyone in the household are working, attach copies of the three most recent paystubs
   - ☐ If you receive unemployment or worker's compensation, attach a copy of the award letter
   - ☐ If you receive Social Security or Disability, attach a copy of the current award letter
   - ☐ If you are self employed, you must include a Schedule C and/or profit and loss statement
   - ❖ NOTE: If you do not have income, we need a letter of room and board from the person who is providing support to your household
2. **Proof of Cash Available to Household**
   - ☐ Most recent copy of bank statements, including checking and saving
   - ☐ Stocks, Bonds, Certificates of Deposits
   - ☐ Any other investments, including real estate
   - ☐ Health Savings Accounts, Medical Savings Accounts, Flexible Spending Arrangements, or Health Reimbursement Arrangements
3. **Cost of Living**
   - ☐ Rent or Lease receipt
     - If you own your home, property taxes and mortgage statement
   - ☐ Utility Bills
   - ☐ Medical bills from other facilities
   - ☐ Monthly Medication Cost from pharmacy (if applies)
4. **Identification – We only require two forms of identification**
   - ☐ Drivers License and/or State ID
   - ☐ Social Security Card
   - ☐ Birth and/or Death Certificate
   - ☐ Marriage license and/or Divorce Decree

NORTHERN COCHISE COMMUNITY HOSPITAL

Northern Cochise Community Hospital, Inc.
Financial Assistance Program

Application Form

Name of Patient:	
Name of Guarantor (financially responsible party):	
Patient's Date of Birth:	Patient's SSN:
Mailing Address:	
Home Phone Number:	Cell Phone Number:

If you have already received a bill, please give us your account number(s):

Household Information: List ALL members of your household

Name	Relation to Patient	Age
Total number of household members(including patient):		

Do you have Health Insurance:……..……☐Yes ☐No

If **YES**, please enclose a copy of the front and back of your insurance card(s).

Did you apply for AHCCCS in the past 6 months?.....☐Yes ☐No

If **YES**, please enclose a copy of your denial letter.

If **NO**, please contact your local DES office for guidance on how to apply for these benefits.

Were these services related to an auto accident,
Workers Compensation, or any Third party Litigation?.....☐Yes ☐No

If **YES**, please provide attorney and/or representative's name and contact information:

Name:	
Phone Number:	
Type of Case:	

Are you eligible for any of the following:……..☐Yes ☐No

If **YES**, please provide documentation verifying eligibility

☐Subsidized School Lunch Program ☐Low Income Subsidized Housing
☐State Funded Prescription Program ☐WIC ☐Food Stamps

NORTHERN COCHISE COMMUNITY HOSPITAL

Northern Cochise Community Hospital, Inc.
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Application Form

Monthly Household Income: Give monthly income for yourself and other household members with proof of income documentation (see documentation checklist)

Income	Self	Spouse and/or other household members	Income	Self	Spouse and/or other household members
Wages/self-employment	$	$	Unemployment	$	$
Social Security	$	$	Worker's Compensation	$	$
Pension or retirement	$	$	Alimony	$	$
Dividends and interest	$	$	Other income	$	$
Rents and royalties	$	$	Total Monthly Family Income	$	$

Do you or other members of your household have a bank account?.....☐Yes ☐No
If **YES**, you must enclose the most recent monthly statement.

Do you have stocks, bonds, or other investments?.....☐Yes ☐No
If **YES**, you must enclose the most recent monthly statement.

Give information about your ownership of vehicles. Write zero for any of these items that you do not own.

Motor Vehicle: (Check one)	☐Own	☐Lease	
Make:	Model:		Year:
Motor Vehicle: (Check one)	☐Own	☐Lease	
Make:	Model:		Year:

Monthly Household and Medical Expenses: Give information about the bills you pay every month.

Expense	Monthly $	Expense	Monthly $	Expense	Monthly $
Rent/Mortgage	$	Utilities	$	Real Estate Taxes	$
Medical Bills	$	Prescriptions	$	Groceries	$

Disclaimer: I herby submit the above statement for the purpose of allowing Northern Cochise Community Hospital Inc. to evaluate my financial status and determine my eligibility for the financial assistance program and do hereby authorize Northern Cochise Community Hospital, Inc., to verify this information as necessary.

I attest that the above information and all income documentation provided are complete and accurate as shown. I realize that should, at any time, any of this information proves to be false, all financial assistance awarded will be reversed, and I will accept responsibility for full and immediate payment of any and all outstanding balances. By applying for Financial Assistance, I also agree to accept payment responsibility for any amount due from me as a result of any partial financial assistance, which may be awarded.

My Signature authorizes Northern Cochise Community Hospital Inc. to verify all information provided on this form. I certify that the above information is true and accurate to the best of my knowledge.

Patient/Guarantor Signature:	Spouse Signature:	Date:
X	X	