



Rocky Mountain Cancer Centers Financial Assessment

Thank you for taking the time to fill out the financial assessment form with Rocky Mountain Cancer Centers.

To insure timely processing of this assessment, we have provided a check list of the items needed by you in order for us to make our determination on your need for financial assistance. Failure to supply this information in a timely manner may result in a denial of your request for financial assistance.

Income: X 3 Months:

Banking Statements X 3 months (most current)
Pay Stubs X 3 months (most current)

Documentation of: Child Support
 Alimony
 Rental Properties
 Land

Additional Income: Social Security Income
 IRA's / CD's / 401k
 Annuities / Life Insurance Policies

Expenses: X 3 Months:

Mortgage/Rent Payments
 Credit Cards
 Loans
 Auto Loans
 All Insurance policies
 Utilities
 Water / Trash / Sewer
 Telephone / Cell Phone
 Cable / Satellite / Internet

Current Medical expenses

Again, failure to include this information may delay processing, and a possible denial.

Rocky Mountain Cancer Centers Financial Assessment Department
303/930-7886



Rocky Mountain Cancer Centers Financial Assessment

Please complete this worksheet and return it to the RMCC Office as soon as possible in order for us to determine if you qualify for financial assistance. We are sincere in our efforts to assist you in a timely manner while maintaining strict confidentiality. Please include copies of all of your income and expenses documentation in order for us to process this application including three months of current banking institution statements.

MRN # _____ / _____

Patient name: _____ Date of Birth _____ SS # _____ U.S. Citizen: Y N

Spouse name: _____ Date of Birth _____ SS # _____ U.S. Citizen: Y N

Child/Other: _____ Date of Birth _____ SS # _____ U.S. Citizen: Y N

Child/Other: _____ Date of Birth _____ SS # _____ U.S. Citizen: Y N

Living in Household

Address _____

City _____ State _____ Zip _____ County _____

Home # _____ Alternative Phone# _____

Have you applied for Medicaid Benefits? ____ YES ____ NO If yes, when: _____ What Office/County _____

If YES, what is the status of your application? _____

Primary Insurance Company _____ Policy# _____

Secondary Insurance Company _____ Policy# _____



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Employment

Company: **Patient:** _____

Spouse: _____

Address: _____

Address: _____

City / State: _____

City / State: _____

of hrs worked per week _____

of hrs worked per week _____

Dates of employment: _____

Dates of employment: _____

Residence

Do you **own / rent** your current residence? _____

Age and relationship of all people who live with you: _____

Assets

Bank Accounts (Checking, Savings & Loan, Credit Unions, Certificate of Deposits, IRA's, Retirement Plans):

3-Months of current copies of all banking account statements are required with this application.

Name of Institution	Type of Account	Account #	Balance



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Life Insurance:

Name of Company	Policy Holder	Amount you can borrow on the policy
_____	_____	_____
_____	_____	_____

Real Estate owned (including mobile homes, undeveloped land, etc.):

Address (including county)	Current value	Loan Balance	Date will be paid off
_____	_____	_____	_____
_____	_____	_____	_____

Motor Vehicles owned (including motorcycles, campers, boats, etc.):

Year and Make	Current Value	Loan Balance	Date will be paid off
1) _____	_____	_____	_____
2) _____	_____	_____	_____
3) _____	_____	_____	_____



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**Other assets or items you own:
(Stocks, bonds, Mutual Funds, IRA, 401K)**

Description	Current Value	Loan Balance	Date will be paid off

Income and Expenses

Monthly Income for the entire household:

Your net pay (Attach two recent pay stubs) _____

Rents paid to you _____

Your spouse's net pay (Attach two recent pay stubs) _____

Commissions/tips _____

Additional residents in household:

Social Security Income _____

_____/ _____
Name Monthly Income

Business Profits _____

_____/ _____
Name Monthly Income

Alimony/Child Support _____

Disability payments (entire household)
(Attach statement) _____

Other income _____
(List source)

Pensions / Annuity payments (entire household) _____

Assistance (Food Stamps, subsidized housing, etc)
(Paid to you) _____

Total monthly income: \$ _____



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Monthly expenses:

(Expenses must be reasonable for the size of family, location and unique circumstance)

Rent / Mortgage _____
 Groceries _____
 Outside Child Care _____
 Estimated tax payments _____

Utilities:

Electricity _____
 Heating oil / natural gas _____
 Water / Trash _____
 HOA payments _____
 Cable / Satellite / Internet _____
 Telephone/cell phone _____

Alimony/Child Support _____
 (Paid by you)
 Transportation _____
 (Taxi, bus, gas, etc)
 Car Payment _____

Medicine _____
 (Not paid by insurance including RX co-payments)

Other (please specify) _____

Insurance:

Auto _____

Health _____
 (Premiums not paid by employer)

Life _____
 (Premiums not paid by employer)

Homeowners/Renters _____

Monthly medical bill payments:



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Name of institute:

Current balance:

Monthly payment amount:

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____
- 6) _____

- _____
- _____
- _____
- _____
- _____
- _____

- _____
- _____
- _____
- _____
- _____
- _____

Installment Payments: (Bank Loans, Credit Cards, Overdraft Protection, Lines of Credit, Collection agencies, etc.)

Name

Minimum monthly payments

Current Balance

- 1) _____
- 2) _____
- 3) _____
- 4) _____

- _____
- _____
- _____
- _____

- _____
- _____
- _____
- _____

Total monthly expenses:

\$ _____

Have you been deemed Medically Disabled by the State of Colorado? ____ YES ____ NO

If YES, how long have you been disabled _____

What is your disabling medical condition _____

Have you applied for disability benefits ____ YES ____ NO If yes, please attach proof of disability



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IN ORDER FOR YOUR APPLICATION TO BE PROCESSED IN A TIMELY MANNER AND TO AVOID DELAYS, PLEASE ATTACH COPIES OF YOUR LAST THREE MONTHS EXPENSES LISTED ON YOUR APPLICATION ALONG WITH CURRENT BANKING STATEMENTS.

I hereby authorize Rocky Mountain Cancer Centers to inquire into my credit history through a credit reporting agency to verify the information I have provided and understand that this information will be used solely for the purpose intended and NOT released to any outside agency.

Signature _____ Date _____

Spouse / Guarantor _____ Date _____

Additional signatures of Adults in the household _____ Date _____

Received from patient _____ Received by RMCC Business Office _____

(Rev: 03-02-2010)

Please return this application to:
Rocky Mountain Cancer Centers
7951 E. Maplewood Ave. Suite 300
Greenwood Village, Co. 80111