Charitable Care Initiative Application
576 West 900 South – Suite 103 | Woods Cross, UT 84010
Phone: 801-397-4163 | Fax: 801-397-4194
www.rockymountaincarefoundation.org

APPLICATION MUST BE FILLED OUT IN FULL TO BE CONSIDERED FOR FUNDING

The following questions inquire as to your personal and financial information and will be held confidential.
The Rocky Mountain Care Foundation will not disclose this information to third parties and it will use it only to assist in funding decisions.

Name_____ Date of Birth_____

Address_____ City_____ State_____ Zip Code_____

Primary Phone Number_____ Alternate Phone Number_____

Number of Adults in the Household _____ Number of Children in the Household _____

Please list the age of all children living at home _____

Are you currently working? ☐ Yes ☐ No ☐ Full Time ☐ Part Time

If not, why? _____

Is your spouse currently working? ☐ Yes ☐ No ☐ Full Time ☐ Part Time

If not, why? _____

Are you currently a student? ☐ Yes ☐ No ☐ Full Time ☐ Part Time

Is your spouse currently a student? ☐ Yes ☐ No ☐ Full Time ☐ Part Time

After receiving funding do you plan to return to work and/or school ☐ Yes ☐ No

Do you currently have health insurance coverage? ☐ Yes ☐ No

Services/Equipment Requested: _____

*Cost of Services/Equipment Requested $*_____ Expected Duration of Treatment_____

Are you currently receiving any of the following?

☐ EBT ☐ WIC ☐ Medicare/Medicaid ☐ Housing Authority (Utilities) ☐ Other

Monthly Wages $_____ Monthly SS, SSI, SSD $_____ Other $_____

Total Monthly Household Income $_____ Total Monthly Household Expenses $_____

Please explain why you are requesting assistance and how it will improve your quality of life:

_____

_____

_____

_____

_____

_____

What other financial support has been received from other organizations; such as insurance, employer reimbursements, state funded programs, church organizations, friends/family, etc.?

_____

_____

I declare that, to the best of my knowledge, the answers I have given are true and correct. I authorize any required verification including contact with my employer, bank, credit verification, and property. I agree to forfeit any and all assistance for fraudulent information supplied in conjunction with this application. I understand that Rocky Mountain Care Foundation is required by law to keep my information confidential, and that if I do not qualify for charitable care, I will be liable for the charges of the healthcare services rendered.

_____ Date _____

Applicant's Signature

_____ Date _____

Referred By | Company

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Disclaimer: Filling out this application does not guarantee financial assistance. The Rocky Mountain Care Foundation's goal is to give financial aid to as many individuals as possible. The individuals need, availability of funds, and the policies and procedures established by the Foundation are used in funding decisions. The Rocky Mountain Care Foundation reserves the right to deny funding to any person or entity. Due to financial restrictions, only one application will be accepted within a 12-month period. A member of the Rocky Mountain Care Foundation team will notify all approvals via phone. All applications will expire 3 months from the date of approval. Any amount exceeding your approved application amount will fall as the sole responsibility of the individual.

----------*Office Use Only*----------

APPROVED ☐

Approved Amount $_____

Expiration Date _____

Grant Funding Source: _____

DENIED ☐

☐ Over Income ☐ Multiple Applications

☐ Out of Scope ☐ Past Medical Bill

☐ Incomplete Application

☐ Other _____

_____ _____

Rocky Mountain Care Foundation Signature *Date*