Northern Arizona Healthcare

1200 North Beaver Street
Flagstaff, Arizona 86001
careassistance@nahealth.com
Phone: 928-773-2025
Fax: 928-214-3682

Completed Financial Assistance Applications, accompanied by all *required documents*, can be submitted for review through email, fax, mail, or visiting in-person.

Flagstaff Medical Center
Attn: Financial Assistance Team
1200 N Beaver Street
Flagstaff, AZ 86001
Phone: **928-773-2025**
Fax: 928-214-3682
Email: careassistance@nahealth.com

Verde Valley Medical Center
Attn: Financial Assistance Team
269 S Candy Lane
Cottonwood, AZ 86326
Phone: **928-773-2025**
Fax: 928-214-3682
Email: careassistance@nahealth.com

For information regarding financial assistance, such as discount calculations and policy details please visit our website. If you have any questions, feel free to contact our billing office at **928-773-2025**
Northern Arizona Healthcare's Financial Assistance Program | NAH

Your financial assistance application will be reviewed and a decision will be made within 15 business days upon receiving the completed application and all necessary documents.

Financial Assistance

Northern Arizona Healthcare (NAH) is dedicated to providing exceptional quality care to every patient. As part of our commitment, we strive to assist our patients with financial obligations associated with their medical care. We have included an application for our Financial Assistance Program to assist in assessing your eligibility for a financial discount.

Eligibility criteria
The NAH financial assistance eligibility criteria are based on current gross household income, and current household size, as well as insurance status.

In order to qualify for NAH's Financial Assistance Program, you must meet the following criteria:

- You are receiving medically necessary care.
- You are not eligible for Medicaid (AHCCCS), or you were approved for Medicaid after the date you received medical services, or you are Medicaid-eligible but receiving services that are not covered by Medicaid.
- You can demonstrate financial need based on the current federal poverty level (FPL). This means that your gross income is less than 400 percent of the minimum amount required to support a family, as determined by the U.S. Department of Health and Human Services.

Once we review your application, you may be asked to apply for Arizona Medicaid's AHCCCS Program. This request stems from the information that you have provided on your application. If you have already applied for AHCCCS and have a current denial letter, please include a copy when submitting your application. If you are in the process of applying for AHCCCS, and or you have already been approved for coverage, please contact our office.

For more details on AHCCCS, please visit https://www.azahcccs.gov

Additional Circumstances that may impose financial hardship:
Court ordered bankruptcy, disability, extended illness, or death. Catastrophic eligibility as determined by NAH Guidelines.

If you do not wish to complete this application, it is imperative that you contact our billing office at 928-773-1848 or 866-733-3017 to make suitable payment arrangements regarding your balance.

Patient Financial Assistance Team
Patient Financial Services
Northern Arizona HealthCare

Northern Arizona Healthcare

Financial Assistance Application

If you are enrolled in AHCCCS QMB, SLMB, or QI1 plan, please DO NOT complete this application. If you are currently approved under Medicaid AHCCCS, please contact our office with your coverage details, 928-773-2025.

Date: _____

Part 1: Patient Information

Patient Name: _____ Date of Birth: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____ Phone Number: _____

Email Address: _____

Marital Status: ☐ Married ☐ Divorced ☐ Widow(er) ☐ Single ☐ Life Partner

Spouse Name: _____ Date of Birth: _____

Employment Status: ☐ Employed ☐ Unemployed ☐ Student ☐ Retired

Does anyone else claim you on their income tax return? ☐ Yes ☐ No If yes, who? _____

Have you applied for Medicaid (AHCCCS)? ☐ Yes ☐ No *Please include your determination letter if applicable.

If the patient is under 18 years of age or the responsible party differs from the patient, we will need to obtain the Guarantor information.

Guarantor Name: _____ Date of Birth: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____ Phone Number: _____

Email Address: _____

Marital Status: ☐ Married ☐ Divorced ☐ Widow(er) ☐ Single ☐ Life Partner

Spouse Name: _____ Date of Birth: _____

Employment Status: ☐ Employed ☐ Unemployed ☐ Student ☐ Retired

Part 2: Family Size (Required)

A dependent is a qualifying child or relative who relies on you for financial support and you can provide documentation.

Household Size (including yourself, spouse, all qualifying dependents): _____

Please provide the following information for all house hold members and their relationship:

Name:		Date of Birth:		Age:		Relationship	
Name:		Date of Birth:		Age:		Relationship	
Name:		Date of Birth:		Age:		Relationship	
Name:		Date of Birth:		Age:		Relationship	
Name:		Date of Birth:		Age:		Relationship	
Name:		Date of Birth:		Age:		Relationship	

Northern Arizona Healthcare

Part 3: Family Income (Required)

Please include all gross income amounts for all sources of income.

Household Gross Income	Patient/Guarantor	Spouse	Other
Employment:			
Social Security:			
Pension/Retirement:			
Unemployment:			
Alimony:			
Child Support:			
Other (describe):			

If you have reported an income of $0, please include a short explanation of how you are financially supporting yourself:

Do you have a Health Savings Account or a Flexible Spending Account? ☐ Yes ☐ No

Have you filed for bankruptcy? ☐ Yes ☐ No If yes, provide the date: _____

Supporting documents required for Financial Assistance approval:

- A complete copy of your signed prior year federal tax return or determination letter from AHCCCS (if applicable).
- 2 months of personal bank statements for all accounts such as checking and savings.
- Proof of total household income which may include:
  - 2 consecutive paycheck stubs or a letter from your employer stating your income (if applicable).
  - A copy of the SSA 1099 benefits letter and/or Pension Statement (if applicable).
  - Copies of unemployment payments (if applicable).
  - Other income to include rent, alimony, child support, or other source (if applicable).

Original documents cannot be returned

Completed Financial Assistance Applications, accompanied by all the ***required documents***, can be submitted for review at the following locations through fax, email, by visiting in-person or by mail:

Northern Arizona Healthcare Flagstaff Medical Center
Attn: Financial Assistance Team
1200 N. Beaver Street Flagstaff, AZ 86001
Phone: 928-773-2025
Fax: 928-214-3682
Email: careassistance@nahealth.com

Disclaimer: I understand that the information I provide will be used solely to determine financial assistance for my outstanding balances with Northern Arizona Healthcare, including hospital and physician services. I acknowledge that if any information I have provided is found to be false, it may result in the reversal of any financial assistance, and I will be responsible for the balance owed. My signature authorizes NAH to verify all information provided on this form, and I certify that the above information is true and accurate to the best of my knowledge.

Signature of Applicant/Legal Guardian: _____ Date: _____