In some instances we are able to provide financial assistance to some of our patients. Enclosed, you will find a financial worksheet. Please take some time to complete all questions on the worksheet to be considered for financial assistance on your current accounts.

Depending on your situation, please also include a copy of the following items to determine if you qualify and submit to the address below:

- Current tax return
- Current W2 form
- Social Security letter
- Unemployment benefits letter
- Last three months of pay check stubs
- If married, please provide spouse’s income information

Applications returned without at least one of these items will not be processed. Please feel free to contact the Customer Service Department, should you have any questions regarding your account(s).

Financial Assistance

University of Colorado Health (UCHealth) is committed to caring for our patients, regardless of their financial circumstances. We work hard to help address patient’s financial responsibilities in a way that is sensitive and fair to their circumstances.

Per Colorado State Senate Bill 12-134, uninsured patients who meet eligibility requirements are qualified to be screened for Charity Care assistance. CICP (Colorado Indigent Care Program) and Medicaid recipients do not qualify for this program. If you are an uninsured patient and need assistance with your medical bill, please call our Customer Service Departments at our different UCHealth locations.

<table>
<thead>
<tr>
<th>Customer Service Phone Numbers</th>
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<tbody>
<tr>
<td>Poudre Valley Hospital/Medical</td>
<td>(877) 711-7510</td>
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<tr>
<td>Center of the Rockies</td>
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<tr>
<td>Memorial Hospital</td>
<td>(877) 711-7420</td>
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<tr>
<td>University of Colorado Hospital</td>
<td>(866) 429-6045</td>
</tr>
<tr>
<td>Colorado Health Medical Group (CHMG)</td>
<td>(877) 711-7480</td>
</tr>
</tbody>
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Sincerely,

University Of Colorado Health
Charity Committee
Financial Worksheet

Name of Patient ____________________________ Name of Guarantor ____________________________

Patient SSN __________________ Guarantor SSN __________________

Address
Street __________________ Apt# __________________ City __________________ Zip Code _______________

Home Phone __________________ Work Phone __________________

Patient’s Employer __________________

Guarantor’s (spouse’s) Employer __________________

CHECKLIST

Patient’s Last 3 Months of income (Gross)*

__________________________________

__________________________________

Guarantor’s (spouse’s) last three months of income (Gross)*

__________________________________

__________________________________

__________________________________

Total Earned Income* __________________

Number of Dependents: ______________

List the Names of Family Members

<table>
<thead>
<tr>
<th>Name</th>
<th>Date of Birth</th>
<th>Social Security Number</th>
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</table>

"Income Sources: Job, Unemployment, Social Security, Alimony, Old Age Pension, Pension Plan, Commissions, Tips, Child Support, Trust Accounts, Rental Income, Interest and other Income.

**COMMENTS:**

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

X ___________________________  X ___________________________

Signature  Date

The information on this worksheet is warranted by the undersigned to be complete and accurate. The undersigned does hereby consent to allow University of Colorado Health & Colorado Health Medical Group (CHMG) to verify all items contained in this worksheet.