Utah Colonoscopy Financial Resources List

Utah Colonoscopy Resources

National

- **National American Cancer Society**
  Phone: 1-800-234-0533
  Information: Their information on funding changes depending on the month, but if you call, they have a person-specific request program where they can contact prior donors and ask if an individual can be considered for funding on a person-specific basis.

Utah

- **Health Access Project (HAP)**
  Phone:
  Information: This program is slightly complex, but potentially very effective. If you meet eligibility requirements, you can call HAP and be referred to a primary care physician who provides no/low-cost primary care. After you meet with this doctor, they can refer you to one of HAP's listed Gastroenterologists who provide no/low-cost colonoscopies. If you already have a primary care physician, that physician can also submit a request to HAP for a Gastroenterologist on your behalf. (More specific to Salt Lake County residents, but serves the whole state)

- **Huntsman Cancer Hospital (forms included)**
  Phone:
  Information: In order to apply, the applicant must provide: the enclosed completed financial statement; a copy of the last 2 months paycheck stubs/income verification; a copy of last year(s) tax return; a copy of your current bank statement and credit card statements; a letter explaining your current financial status. You can leave the "Payment Agreement" section on page 4 blank.

- **Intermountain Healthcare (IHC)**
  Phone: (Financial Assistance Hotline)
  (Eligibility/Payment Programs)
  Information: As long as you have a referral from a doctor, you are eligible to apply for financial assistance through IHC. Coverage is based on income (they provide some coverage for those who make up to 40% more than National Poverty guidelines). There is an application process. For those who aren't eligible for financial assistance, they do offer payment programs as well as a 25% discount for those who pay upfront.

- **University of Utah Hospital**
  Phone:
  Information: They do 12-month payment plans. With no insurance, the University will deduct up to 30% off of the facility fees for medical procedures. However, this does not cover physician fees.

RECREATIONAL VEHICLES (Boats, 4-wheelers, Trailers etc)

YEAR	MAKE	MODEL	LICENSE PLATE	BALANCE OWING	MONTHLY PAYMENT	NAME & ADDRESS OF LEINHOLDER PAID
				$	$	
				$	$	
				$	$	

VALUE OF HOUSEHOLD ITEMS

List Items and Value

Bank Accounts (Savings, Checking, Certificates, Etc.)

Bank and Branch	Account Number	Balance
		$
		$
		$

RETIREMENT ACCOUNTS (IRA, 401K ETC.)

Bank and Branch	Account Number	Balance
		$
		$

EXPENSES

	Monthly Amount	Past Due Amount if Any
Food Expense	$	$
Utilities		
Power	$	$
Gas	$	$
Home Phone	$	$
Cell Phone	$	$
Cable or Satellite	$	$
Internet Provider	$	$
Water	$	$
Clothing		
Cleaning	$	$
Insurance		
Health	$	$
Auto	$	$
Dental	$	$
Homeowner or Renters Insurance		
Is this insurance included in your mortgage or rent payments?	Yes _____ No _____	
Monthly Amount	$	
Day Care Expense	$	$
Fuel	$	$
Newspaper or other Subscriptions	$	$
Entertainment	$	$

LIST OF ALL OUTSTANDING MEDICAL DEBT

Name of Provider	Address	Original Balance	Monthly Payments	Present Balances
_____	_____	$_____	$_____	$_____
_____	_____	$_____	$_____	$_____
_____	_____	$_____	$_____	$_____
_____	_____	$_____	$_____	$_____

LIST ALL DEBT NOW OWING

Creditor Type of Debt (Credit Card, Personal Loans)	Monthly Payments	Present Balances
_____	$_____	$_____
_____	$_____	$_____
_____	$_____	$_____
_____	$_____	$_____

PAYMENT AGREEMENT

I FULLY UNDERSTAND THAT I AM DIRECTLY AND FULLY RESPONSIBLE TO THE UNIVERSITY OF UTAH HOSPITAL AND COMMUNITY CLINICS (UUHC) FOR SERVICES RENDERED FOR THE ABOVE MENTIONED ACCOUNTS/INVOICES AND THAT THIS AGREEMENT IS MADE SOLELY FOR UUHC'S ADDITIONAL PROTECTION AND IN CONSIDERATION OF UUHC AGREEING TO ALLOW ME TO MAKE MONTHLY PAYMENTS, I FURTHER UNDERSTAND THAT SHOULD THE ACCOUNT BE REFERRED TO AN ATTORNEY FOR COLLECTION, I SHALL PAY ALL REASONABLE ATTORNEY'S FEES AND COSTS OF COLLECTION. I FULLY UNDERSTAND IN THE EVENT THAT I DO NOT RECEIVE A MONTHLY STATEMENT, I AM STILL OBLIGATED TO REMIT MY MONTHLY PAYMENT.

SUBJECT TO REVIEW AND APPROVAL BY THE DEPARTMENT:

I AGREE TO PAY THE PROFESSIONAL BILLING OFFICES $_____ PER MONTH BEGINNING: _____

I WILL BE ABLE TO INCREASE MY MONTHLY PAYMENTS TO $_____ PER MONTH BEGINNING: _____

SIGNATURE OF APPLICANT(S)

I HEREBY CERTIFY, AND WOULD BE WILLING TO STATE UNDER OATH, THAT THE INFORMATION CONTAINED ON THIS FORMS IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.
I ALSO UNDERSTAND THAT A CREDIT BUREAU REPORT MAY BE PULLED TO VERIFY RESOURCES.

I UNDERSTAND THAT THIS FINANCIAL ARRANGEMENTS IS APPLICABLE TO THE HOSPITAL AND COMMUNITY CLINICS CHARGES ONLY, PHYSICIAN CHARGES ARE BILLED SEPARATELY AND FINANCIAL ARRANGEMENTS NEED TO BE MADE WITH THE PHYSICIAN'S BILLING SERVICE.

SIGNATURE_____ DATE: _____

SPOUSE'S
SIGNATURE: _____ DATE: _____

PLEASE REMIT ALL CORRESPONDENCE TO:

Privacy Act Notice: THE UNIVERSITY CONFIDENTIALLY MAINTAINS YOUR SOCIAL SECURITY NUMBER FOR ROUTINE USES, SUCH AS FACILITATING DOCUMENT MATCHING, VERIFYING YOUR IDENTITY, TRACKING YOUR MEDICAL HISTORY, DRUG ALLERGIES, AND PREEXISTING CONDITIONS, DEBT COLLECTION, PROVIDING THIS INFORMATION TO PAYORS SUCH AS YOUR INSURANCE COMPANY, MEDICAID, MEDICARE, OR THE INDUSTRIAL COMMISSION. DISCLOSURE OF YOUR SOCIAL SECURITY NUMBER IS VOLUNTARY, BUT NECESSARY TO DETERMINE YOUR ELIGIBILITY FOR DISCOUNTS AND TO EXTEND YOUR CREDIT. IF YOUR PAYOR USES YOUR SOCIAL SECURITY NUMBER AS AN IDENTIFIER, FAILURE TO DISCLOSE YOUR SOCIAL SECURITY NUMBER MAY RESULT IN DELAY OR REFUSAL TO PAY FOR COVERED SERVICES, AND YOU MAY BE BILLED FOR THESE SERVICES. YOUR SOCIAL SECURITY NUMBER WILL BE USED, WITH YOUR CONSENT FOR THESE PURPOSES.