Little Colorado Medical Center

Compassionate Care for Northeast Arizona

Little Colorado Medical Center is pleased to provide you with the following information to help you if you are unable to pay your medical bills.

Little Colorado Medical Center is a nonprofit hospital that offers a range of financial assistance programs to ensure that quality healthcare is accessible for everyone including those who are least able to afford it. Both uninsured patients and those with medical insurance but who may be left with balances they cannot afford to pay may qualify for the following financial assistance programs:

- Our **Free Care Program** offers free care based on family size and income of up to 125 percent of the federal poverty guidelines and other criteria.
- Our **Discounted Care Program** offers discounted care based on family size and income up to 300 percent of the federal poverty guidelines and other criteria. (Please see below)
- Our **Extended Payment Plan Program** offers payment arrangements for patients who may be unable to pay the balance at one time.

Please note that eligibility criteria, terms and conditions vary for each of the financial assistance programs listed above. Our financial counselors can help you further understand if you qualify for any of these programs and can assist you with the application process.

If you have any questions regarding any of our financial assistance programs, please contact Financial Counseling at 928-289-6369.

Federal Poverty Guidelines and Discounted Care Program Percentage Discounts:

Charity Percent			100%	90%	80%	70%	65%
Family Size	Federal Poverty Guidelines 2025	Income Multiplier:	1.25	1.5	1.75	2	3
1	$15,650		$19,563	$23,475	$27,388	$31,300	$46,950
2	$21,150		$26,438	$31,725	$37,013	$42,300	$63,450
3	$26,650		$33,313	$39,975	$46,638	$53,300	$79,950
4	$32,150		$40,188	$48,225	$56,263	$64,300	$96,450
5	$37,650		$47,063	$56,475	$65,888	$75,300	$112,950
6	$43,150		$53,938	$64,725	$75,513	$86,300	$129,450
7	$48,650		$60,813	$72,975	$85,138	$97,300	$145,950
8	$54,150		$67,688	$81,225	$94,763	$108,300	$162,450

add $5,500 for each additional person for families with more than 8 persons

* Obtained from Federal Register (HHS) dated January 2025

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This application can help discount your bill.
It is income based and takes into account your bills and living expenses.
We need copies of the items listed on the check list.

Please return all items listed below:

_____ 1. 2 Months of Bank Account: Checking/Savings Statements

_____ 2. Utility Bills

_____ 3. Last year's taxes

_____ 4. Mortgage/Rent Receipts

_____ 5. Proof of Income

_____ 6. Miscellaneous Receipts

Mail information to:

Little Colorado Medical Center
Attn: Financial Counselor
1501 N. Williamson Ave.
Winslow, AZ 86047
(928)289-6369 (phone)
(928)289-0049 (fax)

Requested information due within 30 days.

Return by: _____

Exhibit A

FINANCIAL ASSISTANCE APPLICATION

PLEASE COMPLETE BOTH SIDES OF THE APPLICATION AND SIGN ON REVERSE SIDE
APPLICATION MUST BE RETURNED TO BUSINESS OFFICE BY:_____

DATE:_____ PATIENT NAME:_____ SSN:_____

ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

PHONE:_____HOME _____OTHER OWN ☐ RENT ☐

INCOME:
HEAD OF HOUSEHOLD:_____ SSN:_____

EMPLOYER:_____ YEARS WORKED:_____ MONTHLY WAGES:_____

SPOUSE:_____ SSN:_____

EMPLOYER:_____ YEARS WORKED:_____ MONTHLY WAGES:_____

ALTERNATIVE MONTHLY INCOME SUCH AS UNEMPLOYMENT, WELFARE, ALIMONY, SSI, PENSION, CHILD SUPPORT, ANNUITIES, STOCKS, INDUSTRIAL, VA. PLEASE LIST ALL THAT APPLY:

_____ **AMOUNT:**_____

_____ **AMOUNT:**_____

_____ **AMOUNT:**_____

BANKING:
CHECKING:_____ BANK:_____ BALANCE:_____

SAVINGS:_____ BANK:_____ BALANCE:_____

REAL ESTATE: MARKET VALUE OF PROPERTY:_____

STOCKS/ANNUITIES:_____

EXPENSE: **AMOUNT**

RENT OR MORTGAGE: _____

UTILITIES (Phone,Gas,Water,Electric ETC)**:** _____

GROCERIES/MONTH: _____

HEALTH INSURANCE: (Medical, Dental, Vision ETC)**:** _____

LIFE INSURANCE: _____

CHILD SUPPORT: _____

OTHER MONTHLY DEBTS (ATTACH LIST IF NECESSARY):

COMMENTS:_____

_____

_____

_____

_____

_____

I CERTIFY THAT THE INFORMATION GIVEN IN THIS APPLICATION IS COMPLETE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT ANY DELIBERATE FALSIFICATION MAY LEAD TO DENIAL OF CONSIDERATION. I HEREBY AUTHORIZE LCMC TO VERIFY INFORMATION LISTED ON THIS APPLICATION, WHICH MAY INCLUDE CONTACT WITH A CREDIT REPORTING AGENCY.

_____ _____

SIGNATURE **DATE**

If you need further assistance or financial resources please consult with the local Department of Economic Security at:
319 E Third St, Winslow AZ 86047 Ph: 928-289-2425

BUSINESS OFFICE USE ONLY

GROSS INCOME(ANN):_____ **CAP GUIDE % OF QUALIFICATION:**_____

CURRENT BALANCE:_____ **LEFT OVER BALANCE:**_____

FINANCIAL COUNSELOR:_____ **ACCOUNT NOTED: Y N**

MONTHLY PYMNTS:_____ **APPROVED BY:**_____