Mt Graham Regional Medical Center
1600 S. 20th Avenue
Safford, AZ 85546

COPE Program
(Charitable Outreach Provision Expense)

Patient Name:_____
Account:_____
Due Back Before:_____

As part of our commitment to quality patient service, Mt. Graham Regional Medical Center offers a COPE Program to patients that meet certain income and financial guidelines. In order for us to determine if a patient qualifies for financial assistance through the COPE Program, this application must be completed and submitted to the Financial Counselor of Mt. Graham Regional Medical Center. You may be asked to provide additional supporting documentation as verification of income and assets. Your cooperation will allow us to review and process your application in a timely manner.

The Mt. Graham Regional Medical Center COPE Program is an uncompensated care service which allows qualifying candidates to have a portion or their entire bill reduced by Mt Graham Regional Medical Center. Applications are available to anyone who wishes to apply.

Once your COPE application is submitted and processed, the application and supportive documentation will be reviewed for eligibility. You may be eligible to have 25%, 50%, 75%, or 100% of your bill reduced. Outstanding accounts that are not in bad debt/collection status may be covered. If the application is not turned in by the requested date as indicated above, the application will be denied and the patient will be financially responsible for the charges. In the event of nonpayment refer to Collections Policy available upon request.

What does COPE cover?

Services performed at Mt. Graham Regional Medical Center. COPE covers physician fees for any provider employed by Mt. Graham Regional Medical Center **(list available upon request).** COPE does not cover any professional fees for providers not employed by Mt. Graham Regional Medical Center, such as surgeons and radiologists. COPE does not cover charges from any ambulance or transportation company.

If you have any questions regarding COPE or need an extension on your due date, please contact the Mt. Graham Regional Medical Center's Financial Counselor at 928-348-3715.

MT GRAHAM REGIONAL MEDICAL CENTER
COPE PROGRAM APPLICATION

The following information must be provided for verification or the application will not be considered. Please do NOT mail us originals. If you mail your application, please send copies of the items listed below.

1. Most current W2 Wage and Salary Statement, and most current 1040 Income Tax Form

2. Proof of income for the last ninety (90) days. Verification may include check stubs, Social Security check, Alimony, Child Support, cash, gifts, etc. Please include all income for anyone in the household who is responsible for contributing to the finances of household.

3. Proof of employment. This may include a paystub and/or letter from the employer on company Letterhead with contact information.

4. Written verification of denial or approval from the Department of Economic Security (DES).

5. Proof of participation in any Governmental Assistance Programs including, but not limited to AHCCCS, Victims Compensation, Indian Health Services, Out of State Medicaid Plans, Social Security, and Social Security Disability.

6. Forms approving or denying Unemployment Compensation or Workmans Compensation, if patient has been unemployed within the last three months.

7. Copy of most recent checking account statement and savings account statement.

8. Proof of rent payment or mortgage payment and remaining balance on mortgage.

9. Estimated value of owned property.

10. Bluebook value of each owned vehicle. Amount of any loans on vehicles or other assets.

11. All medical bills from any other facility with current balances and required monthly payments for all family members for past twelve months. This includes clinics, prescriptions, dental, and vision. Please include any bills you have already paid in the last 12 months.

COPE Income/Expense Worksheet

Patient Information

Patient Name_____Social Security #_____Date of Birth_____

Account #_____ Telephone_____Cell phone_____

Employer_____Address_____Telephone_____

Marital Status □Married □Divorced □Single □Widowed

Spouse Name_____Address_____Telephone_____

Citizenship status_____Country of Birth_____

Financial Information

Total Gross Monthly Income_____

Number of dependents_____

Name of Financial Institution_____

Balance of checking account_____

Balance of Savings account_____

Do you own any property?_____Approximate value of property_____

Do you receive income from any other source?_____If so, how much_____

Household Information

Name: First, Middle Initial, Last	Relationship	Date of Birth

Expenses

Rent / Mortgage _____

Car(s) _____

Make, Year, Model _____

_____

Medical Bills (last 3 months) _____

Child Support _____

Alimony _____

Declaration

I declare under penalty of perjury that the answers I have given are true and correct to the best of my knowledge. I agree to inform the hospital within fourteen days if there are any changes in my (or the person(s) that I am signing for) income, property, assets, expenses, dependants, or address.

I understand that I may be asked to prove the statements that I have made, and my eligibility for Financial Assistance may be subject to verification. This may include, but is not limited to contacting my employer, bank, and pulling a credit report. I do understand that the information that I provide will be kept confidential. Furthermore, I agree to reimburse the hospital for healthcare services rendered as a result of an accident or injury if any proceeds are obtained by litigation or settlement.

_____ _____

Signature Date