APPLICATION FOR MEDICAL EXPENSE ASSISTANCE
Revised: 12/5/2012

The Medical Expense Assistance Fund exists to make a positive difference in the lives of students demonstrating need by providing financial support in order to remove obstacles keeping them from reaching their highest potential.

Please read the following bylaws thoroughly and complete the attached application. Please bear in mind that an incomplete application could affect your chances of being considered for medical expense assistance. Do not leave any part of this application unfinished.

For questions, comments, or concerns regarding this application, contact the Student Health Board at wardshb@colorado.edu.

I. Qualifications
   a. No applicant shall be granted funds for the following cases:
      1. ADHD testing
      2. Non-emergency dental cleanings
      3. Non-emergency chiropractic services
      4. Elective surgeries that are not deemed medically necessary by a provider
      5. Court ordered procedures such as drug testing
   b. The applicant must satisfy the following requirements:
      1. Be lawfully present in the United States
      2. Be a student at the University of Colorado at Boulder who is actively paying student fees
      3. Be able to furnish a student identification number (SIN)
   c. Approval of applicants applying for funds more than once for the same case may be less likely and shall be left to the discretion of the board. This limitation exists due to a need to distribute limited funds among as many students as possible.
   d. The Cost of Attendance Worksheet (page 6 of the application) must be turned in to the Office of Financial Aid for completion. Financial Aid will forward the worksheet to the Student Health Board before the application will be reviewed.
   e. In order to receive aid, applicants must have already received treatment

II. Maximum Allotted Funds
   a. The maximum allotted amount for any given case at any given time will be as follows.

   Note: Tier level is at the discretion of the Student Health Board at the time of the application

   Tier 1 Maximum of up to 40% of what is currently in the Medical Expense Assistance Fund (may include sickness and colds, URIs, vaccines, screenings, and testing)
   Tier 2 Maximum of up to 60% of what is currently in the Medical Expense Assistance Fund (may include MRI/CAT scans, x-rays, PHP (non-emergency) disorders)
   Tier 3 Maximum of up to 80% of what is currently in the Medical Expense Assistance Fund (may include...
III. Additional Information

a. If contacted by the board, the medical expense assistance applicant must respond within two weeks (14 days) in order for the application to remain active.
b. Current Insurance
   1. Applicants who are not on the Student Gold Plan must include detailed information about their insurance coverage including but not limited to the deductible, co-pay, max-life, max out-of-pocket, prescription benefits, exclusions, and limits.
   2. Upon request, applicants shall submit all necessary information related to health insurance, including a copy of their insurance policy and insurance card, the address where the medical claim forms must be submitted, policy number, and any other information deemed necessary.
c. Applicants must include detailed information about their primary source of income including but not limited to job and/or both maternal and paternal benefactors and/or legal guardians.
d. Applicants must disclose and fully explain any prior medical conditions that are relevant to the current medical expense assistance request.
e. Applicants must disclose and fully explain any and all expenses that are relevant to the current medical expense assistance request.

IV. Interview

a. The board may choose to schedule an interview with the chair or co-chair and the applicant.
b. The interview will consist of five questions that will remain the same for all applicants as well as additional information requested by the board.
c. Interview Questions
   1. What is the reason for applying for the Medical Expense Assistance Fund?
   2. What reason(s) make you unable to fund your case?
   3. What other current expenses would prevent you from paying for this case?
      i. Medical
      ii. General expenses
   4. Do you see your case requiring additional funds in the future?
   5. Have you explored other available options for payment of your medical expenses?
      i. Please see “Resources” on the Wardenburg Health Center website at http://www.colorado.edu/healthcenter/.

V. Appeals

a. An applicant may file an appeal if the applicant wishes to challenge the initial decision made by the Student Health Board.
b. Appeals must be filed within 90 calendar days of the date the Student Health Board declined the application. An appeal application can be found at the Student Health Board office or online. Note: Funds granted are contingent upon the funds available at the time of the appeal.
c. An applicant can request an appeal for the following reasons:
   1. The board was misinformed of the medical condition or financial status of the applicant.
   2. Incomplete information was initially recorded on the application.
   3. The applicant’s financial and/or medical situation has changed since the initial application was submitted.
   4. Other
Application for Waiver / Reduction of Charges

Date __________________________

This is a request for: Postponement of charges____ Reduction of charges____ Waiver of charges____

Demographic Information

Name _____________________________ _____________________________ _____________________________

Address _____________________________ _____________________________ _____________________________

City __________________ State __________ Zip __________

SID_____________ Marital Status ____________ Number of dependents____

Date of Birth (day/month/year) ____________________________

Please complete contact information:

Phone (required) __________________________ Please circle one of the following:

Email (required) __________________________ (Home/Work/Cell)

Class: FR SO JR SR Grad

Major __________________________

# Credits this semester: ______________

Are you currently a full fee-paying student? Yes No Not sure

Are you on the Student Gold Insurance Plan? Yes No

Have you previously applied for the Medical Expense Assistance Fund? Yes No

If you are NOT on the Student Gold Insurance Plan, please complete the following section:

<table>
<thead>
<tr>
<th>Primary Insurance Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy Number</td>
</tr>
<tr>
<td>Group Number</td>
</tr>
<tr>
<td>Member Services Phone Number</td>
</tr>
<tr>
<td>Effective Dates</td>
</tr>
<tr>
<td>Deductible</td>
</tr>
</tbody>
</table>

Ri.19 F-1 Original 12/08/00 Rev. 07/17/01, 01/04, 8/08, 05/10, 12/12 S:\WHC Policy Manual\Master e-file\Ri\Ri.19 F-1 Application for Medical Expense Assistance
Application for Waiver / Reduction of Charges

**Treatment Information**  
*Your application will not be processed if this section is incomplete.*

- **Type of treatment**
- **Place of treatment or WHC Department**
- **Dates of treatment**
- **Amount covered by your insurance (if applicable)**
- **Requested amount to be reduced or waived**
- **Are you currently receiving on-going care (e.g., psychiatry, physical therapy)?**

**Explanation of your financial and medical situation**  
*(you may attach additional information if desired)*

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
Additional Questions

Do you anticipate this case to require additional funds?  
Yes (explain)  
No

Please list your primary source of income, example, relatives, job(s), and/or financial aid.

Please list and explain any reoccurring / relevant medical conditions that have persisted over the last three years.

Please list and explain any reoccurring / relevant medical expenses that have persisted over the last three years.

What other current expenses would prevent you from paying for this case? Include both medical and general expenses.

How did you hear about the Medical Expense Assistance Fund?

My signature attests that I authorize the Wardenburg Health Board to access any and all information regarding my current health care plan.

My signature attests that I have read and agree to the terms listed in the Medical Expense Assistance Bylaws.

My signature attests that the information on this application is complete and accurate to the best of my knowledge. I give my permission for the CUSG Student Health Board or Wardenburg Health Center to verify any information contained in my request. Any person making false statements or misrepresentations is subject to the University Student Conduct Code.

______________________________  ______________________________
Signature of applicant  Date
Cost of Attendance Worksheet

Please sign and submit this form to the Office of Financial Aid in Regent Hall. Once complete, the Office of Financial Aid will forward the form to the Student Health Board. No further action is required by the applicant.

To be completed by student:

Student's Name (Last, First, M.I.). Please print.

Student Identification Number (SID)

I authorize the Office of Financial Aid to release my financial aid information to the CUSG Student Health Board to help determine my eligibility for medical expense assistance.

Student signature Date

To be completed by the Office of Financial Aid:

<table>
<thead>
<tr>
<th>Cost of Attendance</th>
<th>Fall / Spring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tuition / fees</td>
<td></td>
</tr>
<tr>
<td>Books &amp; supplies</td>
<td></td>
</tr>
<tr>
<td>Room &amp; board</td>
<td></td>
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<tr>
<td>Medical expenses</td>
<td></td>
</tr>
<tr>
<td>Personal expenses</td>
<td></td>
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<tr>
<td>Travel</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>$</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Financial Resources</th>
<th>Fall / Spring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federal Pell Grant</td>
<td></td>
</tr>
<tr>
<td>Other federal/state grants</td>
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<tr>
<td>Scholarships</td>
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<tr>
<td>Work-study</td>
<td></td>
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<tr>
<td>Student loans</td>
<td></td>
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<tr>
<td>Parent loans</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>$</td>
</tr>
</tbody>
</table>

Comments regarding financial aid eligibility:

By signing below I attest that the information provided is true and accurate to the best of my knowledge.

Financial Aid Representative signature Date

Email Address ___________________________________________________________