Campus Box 119 Boulder, Colorado 80309-0119
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APPLICATION FOR MEDICAL EXPENSE ASSISTANCE

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. Non-emergency dental cleanings
   2. ADHD testing without a written referral or provider's note
   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. Applicants are encouraged to present all expected medical bills.

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 emergency, trauma)*

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. In order to file an appeal, an applicant shall have 90 calendar days from 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 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 _____
Last First Middle

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: (Home/Work/Cell)

Email (required) _____

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:

Primary Insurance Information

Policy Number _____
Group Number _____
Member Services Phone Number
_____
Effective Dates _____
Deductible _____

Max-Life _____
Max-Out-of-Pocket _____
Exclusions and Limits_____
Prescription Benefits _____
Co-Pay _____

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:

Cost of Attendance	Fall / Spring
Tuition / fees	
Books & supplies	
Room & board	
Medical expenses	
Personal expenses	
Travel	
TOTAL	$

Financial Resources	Fall / Spring
Federal Pell Grant	
Other federal/state grants	
Scholarships	
Work-study	
Student loans	
Parent loans	
TOTAL	$

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 _____