



Application for Medical Financial Assistance Instructions and Information

Thank you for inquiring about financial assistance. Please review the following information:

- Applicants must be aged 60+ and a resident of Broomfield.
- Requests need to be primarily medical in nature.
- Only completed, signed and dated applications will be considered.
- Submit the Financial Assistance Application to the Community Resource Coordinator, Senior Services, 280 Spader Way, Broomfield CO 80020, 303-464-5529 or email lclemesen@broomfield.org.
- **Applicants must obtain a care plan and cost estimate for the product or service they need and provide it to the Community Resource Coordinator along with the application for financial assistance. The plan or estimate must include the applicant's name, recommended product or service, cost, guarantee/warranty, return policy, trial period and maintenance detail, and other pertinent information, if applicable.**
- Funding is provided after the service or product is completed/delivered (with some exceptions). *Note: not all organizations are willing to be paid after the fact, however the Resource Coordinator will provide a Confirmation of Financial Assistance letter if needed.*
- Checks are made payable to the service provider and are mailed out the 2nd week of the month following the application approval.
- Financial assistance cannot be authorized to reimburse for products or services already rendered.
- Funding is limited and may not be available at the time of application but every effort is made to find and provide assistance. Any balance after payment is made is the responsibility of the applicant/recipient.
- Applicants should be prepared to contribute what they can toward the total cost of the request.
- For more information, please contact the Community Resources Coordinator at 303-464-5529.



APPLICATION FOR MEDICAL FINANCIAL ASSISTANCE

City and County of Broomfield Senior Services



The **Medical Financial Assistance Program** provides limited, one-time financial support to low-income older adults for essential medical needs that are not fully covered by insurance or other benefit programs. This may include services such as dentures, dental care, hearing aids, eyeglasses, and foot care.

This program is **NOT** intended for routine medical care, ongoing expenses, or services already rendered. Each request is reviewed on a case-by-case basis to determine eligibility and urgency.

Incomplete applications will not be processed. Please return the application to Broomfield Senior Services, Attn: Resource Coordinator, at 280 Spader Way, Broomfield, CO 80020. For questions, please call 303-464-5529 or email lclemesen@broomfield.org.

APPLICANT INFORMATION

Last Name _____ First Name _____ MI _____
Street Address _____ Apt/Lot # _____
City _____ State _____ Zip _____
Phone _____ Email _____
Date of Birth _____ Age _____

REQUEST DETAILS

Describe the need for assistance (what is needed and why is it essential?):

Total Amount Requested: \$ _____

Is this a one-time expense? Yes No (This program does *not* cover ongoing or recurring expenses.)

PAYMENT INFORMATION

Please note: If approved, payment will be issued via check directly to the medical provider or vendor. Payments cannot be made payable to the applicant.

Vendor Name (Name to make the check payable to) _____
Vendor Mailing Address _____ Apt/Lot # _____
City _____ State _____ Zip _____
Vendor Phone _____ Email _____

CURRENT ASSISTANCE PROGRAMS

Please check all programs you are currently enrolled in:

- | | |
|--|---|
| <input type="checkbox"/> Social Security Benefits (SSI/SSDI) | <input type="checkbox"/> SNAP (Food Stamps) |
| <input type="checkbox"/> Medicaid | <input type="checkbox"/> Veteran Benefits (VA) |
| <input type="checkbox"/> Medicare Savings Program | <input type="checkbox"/> Medicaid Waiver Services |
| <input type="checkbox"/> Housing Assistance (Voucher, TBRA) | <input type="checkbox"/> Other: _____ |

FINANCIAL ELIGIBILITY

This program is for seniors whose **gross household income is at or below 40% of the Area Median Income (AMI)** for Broomfield County. For eligibility purposes, “household” refers to the applicant and any individuals they are financially responsible for.

MONTHLY INCOME LIMITS

COUNTY	1 PERSON	2 PERSON	3 PERSON	4 PERSON	5 PERSON
BROOMFIELD	\$3,270	\$3,737	\$4,203	\$4,670	\$5,047

Please complete the section below to help determine your eligibility:

Number of household members you are financially responsible for (including yourself): _____

Total gross monthly income for all household members listed above (before taxes): \$_____

Sources of income (check all that apply): Social Security SSI/SSDI Pension

Employment VA Benefits Other: _____

OTHER RESOURCES

This program is intended only for needs **not covered** by insurance or other benefit programs.

Have you contacted other programs or agencies to try to meet this need?

Yes No

If yes, list where you applied and the outcome (denied, not eligible, no response, etc.):

Why are you unable to pay for this expense yourself?

Is this expense covered or reimbursed by any insurance, benefit, or organization?

Yes No

If yes, please explain:

INSURANCE

Please check and provide any insurance coverage that may apply to your request:

- **Medical Insurance:** Yes No
 - Provider: _____
- **Vision Insurance:** Yes No
 - Provider: _____
- **Dental Insurance:** Yes No
 - Provider: _____

Have you checked with your insurance to see if this need is covered? Yes No

If not, please explain why: _____

DOCUMENTATION

Please include any supporting documentation that will help us review your request including, but not limited to:

- Estimate or invoice for the item/service - **REQUIRED**
- Doctor's note or referral - **REQUIRED**
- Proof of efforts to seek other help (denial letters, emails, notes)
- Proof of income (optional but helpful)

AGREEMENT & SIGNATURE

I, the applicant, understand that if I am approved for financial assistance from Senior Resources of Broomfield, Inc., Broomfield Community Foundation, Broomfield Rotary, or other charitable organization, the funds will be paid directly to the vendor providing services, not to me personally.

I, the applicant, understand the vendor **MUST** agree to provide the services fully and completely, **PRIOR** to payment, and that it is my responsibility to coordinate the services with the vendor.

I, the applicant, indemnify and hold City and County of Broomfield, Senior Resources of Broomfield, Inc, Broomfield Community Foundation, Broomfield Rotary, or other charitable funding organization harmless from any and all claims, disputes, liabilities, or causes of action arising out of the agreement to provide assistance or the providing of financial assistance, or arising out of services and goods sold or provided to recipients of financial assistance.

My signature below indicates my agreement to these statements and attests that the information provided in this application is true and accurate to the best of my knowledge.

I understand that submitting an application does not guarantee approval, and that this program is for one-time, medical needs not covered by other resources.

SIGNATURE: _____ **DATE:** _____

FOR STAFF USE ONLY

Request Approved Y N

Approved Amount: _____

Approved By: _____

Date: _____

Comments: _____