Utah Partners for Health Application

Providing Healthcare Access for Those in Need

The Utah Partners for Health model is designed to care for the underserved, uninsured, and underrepresented. It is a cooperation of health care professionals and the community to provide health care access for those in need. The providers on our program donate a substantial portion of their billing. Please thank them for their support. Your co-pay is meant to be a small portion of the total bill. *Utah Partners for Health is a 501c3 charitable organization.*

To qualify you must meet the following criteria:

- Live in Magna , West Valley City, or Kearns. Have a household income of less than $35,000 – your employment check stub or other official document is needed to verify.
- Be currently uninsured.
- Have a medical need

This Form must be filled out with each visit. To qualify for additional appointments please call 250-9638 x131.

PATIENT INFORMATION (If the patient is a child, please

Name_____Date of Birth_____ Age____

Guardian's Name if the patient is a child _____

Street_____City, State, Zip_____

Employer_____Occupation_____

Phone_____Marital Status: Single: ☐ Married ☐ Separated: ☐ Divorced: ☐ Widowed: ☐

How many children do you have? _____ How many people live in your household _____

Female Head of Household ☐ (Check if YES)

Your individual Income per month _____ Your total household income per month _____

Ethnicity: (Select only one) Hispanic or Latino ☐ Not Hispanic or Latino ☐

Race: (Select one or more) American Indian or Alaskan Native ☐ Asian ☐ Black/African Am. ☐ Pacific Islander ☐ White ☐

MEDICAL NEED (Please describe your medical need)

_____

CONFIDENTIALITY STATEMENT

Utah Partners for Health will disclose your protected health information to provide, coordinate, or manage your health care and any related services, and to support the business activities of the nonprofit charitable organization.

VOLUNTARY DONATION OPTION - CONTRIBUTE TO HELP OTHERS IN NEED
(This is not required. It is an opportunity to help other patients receive care and keep the costs of our program down)

Check one:

☐ Yes, I would like to contribute an extra $5.00 to my co-payment

☐ Yes, I would like to contribute this amount to my co-payment $_____

☐ I cannot make an additional donation at this time.

Signature _____ Date _____

Please return completed application and attachments to Utah Partners for Health, 8211 W. 3500 S, Magna, UT 84044
For more information: www.upfh.org or 250-9638 x131. Applications are also available on our website.