Mayers Memorial Hospital District

Dear Patient,

Thank you for choosing Mayers Memorial Hospital for your healthcare needs. Attached is the application for our Discount Payment and Charity Care Program. The required information necessary to process the application is listed below. It is recommended that applications be submitted complete within 30 days from the date you received it.

Discount Payment

1) Complete Application- Sections 1-4a

2) Supply proof of identity by copy of a valid:
   a. driver license
   b. state identification card, or
   c. passport

3) Documentation of household income, supply one of the following:
   a. Current W-2 withholding form or Income Tax statement form from the previous year, or
   b. Pay stubs for all working family members from the previous three months.

Charity Care

1) Complete Application – All sections 1-4 a and b

2) Supply proof of identity by copy of a valid:
   a. driver license
   b. state identification card, or
   c. passport

3) Documentation of non-coverage (denial) from Medi-Cal and/or County Medical Services Program (CMSP) for service on the date performed.

4) Documentation of household income, supply one of the following:
   a. Current W-2 withholding form or Income Tax statement form from the previous year, or
   b. Pay stubs for all working family members from the previous three months.

5) Documentation of monetary assets, supply the following:
   a. Most current bank statement, and any additional information or statements on all monetary assets.
   b. Statements on retirement or deferred-compensation plans qualified under the Internal Revenue code. Nonqualified deferred-compensation plans shall not be included.
   c. Signed waiver or release from the patient or the patient's family, authorizing the hospital to obtain account information from the financial and/or commercial institutions, or other entities that hold or maintain monetary assets, to verify their value.

- All incomplete applications will be returned with a letter indicating what corrections need to be made. Complete applications will be processed and verification of accuracy of the information submitted, including contacting employers for verification of employment, will be made.

- All properly submitted applications will be processed within 10 business days. A letter will be mailed notifying you of the decision made.

- Any application submitted for Charity Care consideration that does not qualify will automatically be considered for the Discount Payment Program, a separate application is not necessary.

If you have any questions, need additional information or would like assistance, please contact:
Colene Watson
Financial Counselor
Monday –Friday 8:00am- 4:30pm
(530)336-5511, ext. 1152

Mayers Memorial Hospital District

Discount Payment and Charity Care Application

1) RESPONSIBLE PARTY INFORMATION

Last Name _____ First Name _____ Social Security # _____ Date of Birth _____

Home (Physical) Address _____ Mailing Address _____ City _____ State/ Zip Code _____

Home phone # _____ Alternate/Cell Phone # _____

Employer Name _____ Job Function/Title _____ Employer Phone # _____

Gross Annual Income _____ Employer's address: Street, City, State, Zip _____

Spouse's Name _____ Social Security # _____ Date of Birth _____

Employer Name _____ Job Function/Title _____ Employer Phone # _____

Gross Annual Income _____ Employer's address: Street, City, State, Zip _____

2) People In Household

	Name	Relationship to Patient	Date of Birth	Employer	Employer Telephone
1					
2					
3					
4					
5					
6					

3) Income & Asset Information

In order to determine your eligibility for the MMHD Discount Payment or Charity Care program, please provide us with information about your gross annual income. If you are applying for Charity Care, both Income and Qualified Monetary Assets need to be completed.

a) Income (monthly)

Job Income:	$_____
Spouse Job Income:	$_____
Business Income:	$_____
Rental Income:	$_____
Interest/Dividend Income	$_____
Social Security Income:	$_____
Alimony or Support Income:	$_____
Other Income:	$_____
Total Monthly Income	**$_____**

b) Qualified Monetary Assets (only complete if applying for Charity Care.)

Checking Account(s)	$_____
Savings Account (s)	$_____
Stock, Bonds & CDs	$_____
Other:_____	$_____
Other:_____	$_____
Other:_____	$_____
Other:_____	$_____
Total Assets	**$_____**

4) Documentation Check List

Please attach copies of the requested documents below.

1) Proof of Identity

2) Proof of Income (check one)
- ☐ Current W-2 withholding form
- ☐ Income Tax Return from previous year
- ☐ Past 3 months pay stubs

For applications being submitted for Charity Care consideration, please supply the additional documents requested below.

3) Proof of denial from Medi-Cal and/or County Services Medical Program (CMSP)

4) Proof of Monetary Assets (check all that apply)
- ☐ Most Current checking account statement
- ☐ Most current savings account statement
- ☐ Most current retirement account statement
- ☐ Most current deferred-compensation plan statement

By signing below you agree to be considered for MMHD Discount Payment or Charity Care Program. Additionally, you certify that all of the statements and information provided on this application are true and complete to the best of your knowledge. Should it be determined that the information you provided is incomplete or false, any discount applied may be reversed and payment in full may be expected from you. By signing below, you authorize Mayers Memorial Hospital District to check references and credit history in order to determine eligibility for Discount Payment or Charity Care consideration.

You further agree by signing below, that if you receive payment from an insurance company, workers' compensation plan, or any other third party, to inform the hospital of any such payment. Mayers Memorial Hospital District retains the right to collect the original, full billed amount for rendered services should a third party provide you with payment.

_____ _____

Signature of Applicant **Date**

For Office Use Only

_____ _____ _____ _____

Date Received Date Processed Processed By Manager Approval

☐ Discount Approved _____ ☐ Charity Care Approved ☐ Denied _____

Amount Reason