

FINANCIAL SCREENING FORM

Mad River Community Hospital is able to offer adjustments to your account balance after we assess your ability to pay based upon our Financial Screening Policy. Please complete the form below. If we do not hear from you "within thirty days, we will resume our normal collections process."

| | |
|---------------------------------|----------------------|
| Guarantor Name | Monthly Expenses |
| Account Number(s) | Rent/House Payment |
| Family Size | Insurance |
| Guarantor Gross Income | Loan Payments |
| Spouse Gross Income | Credit Card Payments |
| Other Income | Utilities/Telephone |
| "(unemployment, alimony, child" | Medical Expenses |
| "support, pension, dividends," | Food |
| "rental property, etc.)" | Other |
| Total Monthly Gross Income | Total |
| Total Net Income | |
| (after taxes and deductions) | |

Employer Name & Address:

"If you have special circumstances that you would like to explain, please use space below."

IMPORTANT

PLEASE SUBMIT WITH THIS APPLICATION: A COPY OF LAST YEARS INCOME TAX STATEMENT FOR ALL WAGE

"EARNERS IN THE HOUSEHOLD, OR A W-2 WAGE STATEMENT FOR ALL WAGE EARNERS OR COPIES OF THE LAST TWO "

WAGE STUBS FOR ALL WAGE EARNERS. DOCUMENTATION MUST ALSO BE PROVIDED TO VALIDATE THE NUMBER

OF DEPENDENTS THAT ARE BEING CLAIMED.

By signing this form you are attesting that the information provided is both true and accurate.

Responsible Party/Guarantor signature
Responsible Party/Guarantor signature

Date
Date

DO NOT COMPLETE THE FOLLOWING - FOR HOSPITAL USE ONLY

" Based on the financial screening information and policy guidelines, the responsible party is eligible for a _____ % " policy or charity discount and agrees to pay their remaining portion.

Hospital Representative

Date

"3800 Janes Road, Arcata, CA 95521 / P. O. Box 1115, Arcata, CA 95518-1115"
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