



Patient Financial Services
228 W. McDowell Avenue
Alturas, CA 96101
530-233-7009

Dear Patient,

You have requested financial assistance for one or more bills with Modoc Medical Center. Please complete the attached application in its entirety, and sign where indicated. Please also provide the required documents, as outlined in this application. Upon receiving this application and required documentation back from you we will be able to determine the extent to which you qualify for a Reasonable Payment Plan, Discount Payment Program or Charity Care Program.

Our Patient Financial Services Department is available for personal assistance by appointment. During this appointment, they can screen and assist with finding the best resolution for your individual needs. Additionally, they are able to assist patients in applying for Medi-Cal and provide information on other insurance plans through the California Health Benefit Exchange, commonly known as Covered California.

It is our goal to help find a planned solution for you to pay your bills to MMC.

Please note the following information:

- If assistance is needed to complete this application, please contact Patient Financial Services at the number below to schedule an appointment.
- All properly submitted applications will be processed within 10 business days of receipt. A final letter of determination will be provided.
- Any incomplete applications will be returned upon receipt with a letter advising what information is needed in order to process the application. Complete applications will remain valid for 180 days.
- Any application submitted for Charity Care consideration that does not qualify will automatically be considered for the Discount Payment Program and Reasonable Payment Plan, a separate application is not necessary.

Return your completed application along with all supporting documentation within 30 days of receipt of the application. Applications may be mailed, faxed, or emailed to the following:

**Modoc Medical Center
Attn: Patient Financial Services
228 W. McDowell Avenue
Alturas, CA 96101**

**Fax: 530-233-7609, Attention: Patient Financial Services
E-mail: p.chrysler@modocmedicalcenter.org**

Thank you for choosing Modoc Medical Center for your health care needs. We look forward to assisting you with your request.

Best Regards,

Paulette Chrysler
Patient Financial Services
(530)233-7009

Financial Assistance Application

1) RESPONSIBLE PARTY INFORMATION

Last Name	First Name	Social Security Number	Date of Birth
Home (Physical) Address	Mailing Address	City	State/Zip Code
Home Phone Number	Alternate/Cell Number		
Employer Name	Job Function/Title	Employer Phone #	
Gross Annual Income	Employer's Address: Street, City, State, Zip Code		
Spouse's Name	Social Security Number	Date of Birth	
Employer Name	Job Function/Title	Employer Phone #	
Gross Annual Income	Employer's Address: Street, City, State, Zip Code		

2) Health Insurance Information

Current Health Insurance Company	Current Identification #	Current Group #
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- Please check this box if no insurance is currently held
 Please check this box if a Medi-Cal application has been filed and denied

3) People In Household

	Name	Relationship to Patient	Date of Birth	Employer	Employer Telephone
1					
2					
3					
4					
5					
6					
7					
8					

4) Income & Asset Information

In order to determine the extent of your eligibility for the MMC Reasonable Payment Plan, Discount Payment, or Charity Care Program, please complete the required sections below. Please note, different information is required for each program.

Monthly Income: Required for Reasonable Payment Plan, Discount Payment Program, and Charity Care.

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

Required Documentation
 One or more of the following:

- All paystubs from the last 90 days.
- Most current W-2 for all working adults.
- Copy of the most recent filed tax return.
- Social Security Statement.
- If no income, please attach a signed letter stating circumstances.

Current Monthly Essential Living Expenses: Required for Reasonable Payment Plan

Mortgage/Rent Payment \$ _____
 Insurance Premiums (health, auto, home) \$ _____
 Utilities (Gas, Elect., Water, Phone) \$ _____
 Automobile Payment(s) \$ _____
 Food \$ _____
 Other: _____ \$ _____
 Other: _____ \$ _____
Total Monthly Essential Living Expenses \$ _____

Required Documentation
 One or more of the following:

- Proof of amount of most recent mortgage/rent paid.
- Most current statements for any expense listed/claimed on this application.
- Receipts/proof of payment for amounts paid for food/medical expenses paid in the last full month

Qualified Monetary Assets: Required for Charity Care

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

Required Documentation
 One or more of the following:

- Most recent bank statements.
- Most recent Quarterly Statement for stock(s), bond(s), or CD(s).
- Other: Most recent statement showing total monetary worth of asset.

By signing below you are asking to be considered for MMC Discount Payment, Reasonable 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 Modoc Medical Center to check your 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 MMC of any such payment. Modoc Medical Center retains the right to collect the original, full billed amount for rendered services should a third-party provide you with payment for those services.

Signature of Applicant (Responsible Party)

Date