Date: _____

Patient/Guarantor: _____ Mailing Address: _____

Account Number: _____ _____

Home Phone Number: _____ Cell Phone: _____

_____

In order to be considered for Plumas District Hospital's Charity Care Plan, the information below must be completed and returned to our office along with all required documentation.

Income Information

Number of Dependents: _____ Your Employer: _____

Your Gross Income _____ *(Select one):* ☐monthly ☐bi-weekly ☐weekly

Spouse Name: _____ Spouse Employer: _____

Spouse Gross Income: _____ *(Select one):* ☐monthly ☐bi-weekly ☐weekly

Other Income: _____ (*Select one):* ☐month _____ ☐ year _____

(Select all that apply): ☐dividends ☐annuities ☐royalties ☐ rental property ☐other

TOTAL MONTHLY INCOME: _____ **TOTAL YEARLY INCOME**: _____

(Total of Gross Income, Spouse Gross Income, and Other Income)

Banking Account Information

Checking account with: _____ Account Balance: _____

Savings Account with: _____ Account Balance: _____

Other Assets: _____

(Do not include retirement plans or deferred compensation plans - use additional sheet if necessary)

Expenses Information

I am *(check one):* ☐Renting ☐Buying Monthly payment:

_____

If a homeowner, for how long: _____

Mortgage/Rent payments current *(Check one):* ☐Yes ☐No If no, how far behind: _____

Auto payment: _____ Year/Make/Model: _____

Are you current *(Check one):* ☐Yes ☐No Auto financing through: _____

Auto payment: _____ Year/Make/Model: _____

Are you current *(Check one):* ☐Yes ☐No Auto financing through: _____

Auto payment: _____ Year/Make/Model: _____

Are you current *(Check one):* ☐Yes ☐No Auto financing through: _____

Total Personal Loans: _____ Total Monthly Payment: _____

Are you current *(Check one):* ☐Yes ☐No

PLEASE COMPLETE BOTH SIDES OF THIS FORM.

Credit Cards (Select One): □□□Visa □ MasterCard □Discover □□□ Other
Balance: _____ Limit:_____ Monthly Payment: _____
Are you current *(Check one):* □□Yes □□No

Credit Cards (Select One): □□□Visa □ MasterCard □Discover □□□ Other
Balance: _____ Limit:_____ Monthly Payment: _____
Are you current *(Check one):* □□Yes □□No
Credit Cards (Select One): □□□Visa □ MasterCard □Discover □□□ Other
Balance: _____ Limit:_____ Monthly Payment: _____
Are you current *(Check one):* □□Yes □□No

Other Credit Cards *(Name of Credit Cards:)* _____
Total owed: _____ Total Monthly Payment: _____ Are you current *(Check one):* □□Yes
□□No

Total Medical Bills: _____ Monthly Payment: _____Are you current *(Check one):* □□Yes
□□No
Average Monthly Pharmacy Bills: _____ Average Monthly Health & Car Insurance: _____

Average Monthly Food Bill: _____ Monthly Utility Bills: _____
(Total of telephone, electricity, gas, garbage, etc.)

TOTAL MONTHLY EXPENSES: _____ *(Total of all expenses listed above)*

If your monthly expenses exceed your monthly income, please describe how you are meeting your expenses:

_____

_____

_____

_____

By signing this form, I agree to allow Plumas District Hospital to check my credit history to determine my eligibility.

(Signature of Patient or Guarantor) *Date*

(Signature of Spouse) *Date*

CHARITY CARE STATEMENT OF FINANCIAL CONDITION- Plumas District Hospital's Charity Care Plan and Discount Payment Policy is consistent with provisions in Senate Bill 1276 which was enacted on 9/28/2014