# FINANCIAL ASSISTANCE APPLICATION

**PATIENT INFORMATION:**

| | |
|---|---|
| **Last Name**: | **First Name**: |
| **SSN:** | **Date of Birth**: |
| **Physical Address**: **City**: **State**: **Zip:** | |
| **Mailing Address:** **City:** **State**: **Zip:** | |
| **Home Phone Number:** **Message Phone:** ( ) ( ) | |

**FAMILY STATUS:** **Please list all dependants**

| Name: | Age: | Relationship: |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |

**FAMILY SIZE: _____**

**EMPLOYMENT:**

| | |
|---|---|
| **Employer:** **Title/Position:** | |
| **Address:** **City:** **State:** **Zip:** | |
| **Phone Number:** ( ) | |

****** If self-employed******

| | |
|---|---|
| **Name Of Business:** **Type of Business:** | |
| **Address:** **City:** **State:** **Zip:** | |
| **Phone Number:** ( ) | **How long have you owed your business?** |

**How much out-of-pocket medical expenses were paid in the last 12 months?**

Please provide documentation of out-of-pocket medical cost.
**$**_____

**CURRENT MONTHLY INCOME: (***Please include all income in household)*

| | |
|---|---|
| Gross Income (before deductions) | $ |
| Income from Operating Business (if self employed) | $ |
| Interest & Dividends | $ |
| Real Estate or Personal Property | $ |
| Social Security | $ |
| Alimony and/or Child Support Received | $ |
| Other | $ |

By signing this form, I agree to allow Fairchild Medical Center to check employment and credit history for the purpose of determining my eligibility for a financial discount. I understand that I may be required to provide proof of the information I am providing. I also understand that if the information is determined to be false, the documentation will result in a denial and I will be liable for charges for services provided. I affirm this information is true and correct to the best of my knowledge.

Signature: _____ Date: _____

**In order for this application to be considered for financial assistance, the following documents are required.**

- Completed Financial Assistance Application Form
- A copy of the prior year tax return or
- Documentation representative of current income ( 2 months of most current pay stubs)
- A copy of social security, disability, or unemployment award letter
- A copy of a state CMSP/Medi-Cal denial notice (if applicable). You may obtain this by contacting the Department Of Social Services in the area in which you live. All potentially eligible patients must provide a valid "Notice of Action" from Department of Social Services stating that completion of the application and reason for acceptance or denial. *(Please note: Any "Notice of Action" stating a failure to provide information or failure to participate in the interview will not be accepted in consideration of this application for financial assistance.)*

**Please return your completed application with <u>all</u> requested forms in the enclosed self-addressed stamped envelope within 10 days. Please contact <u>Renee' Peterson</u> @ (530) 841-6255 if you have any questions.**

***If eligible for payment assistance, discounts will be applied to services rendered one year prior from the date of application. If there are services rendered beyond one year of application, special requirements are needed. Please refer to the financial counselor for more detail regarding requirements.***
***Please be advised that this is not a guarantee that financial assistance will be awarded; and payments should continue on a regular basis until determination has been made. Your application and the information provided will be reviewed and verified. A decision will be provided to you in writing.***

Thank you for your cooperation. We look forward to being of assistance to you.

**Return by this Date:_____**

**Account Number:_____**
**Account Balance $_____**