MOUNTAIN COMMUNITIES HEALTCARE DISTRICT – Confidential Financial Statement (Application)

Patient Name_____	**DOS:** _____
Patient Number_____	**Confidential Financial Statement (Application)**

RESPONSIBLE PARTY

Name		Marital Status	Social Security Number
Street Address, City, State, Zip		How long at this address	Home Phone
Employers Name and Address (If Unemployed –How Long)			Business Phone
Position / Title	Monthly income – Gross	Monthly income – Net	Length of current employment

SPOUSE

Name			Social Security Number
Employer Name and Address			Business Phone
Position / Title	Monthly income – Gross	Monthly income – Net	Length of current employment

DEPENDENTS

Name & Year of Birth of all persons in household	Total Number of Persons in Household____	Do Any Other Persons Contribute? If Yes, Amount: Yes/No _____ Amount _____

INCOME PER MONTH & ASSETS

Dividends, Interest	$	**Child Support / Alimony**	$
Public Assistance / Food Stamps	$	Rental Income	$
Social Security	$	Grants	$
Unemployment Compensation	$	IRA	$
Workers' Compensation	$	Other	$
Savings	$		$

EXPENSES PER MONTH

Mortgage / Rent $	Balance: $	Medical / Dental	$
Own Home? (Yes/No)		Doctor – Name	
Food	$	Doctor – Name	$
Utilities:		Doctor – Name	$
Electric	$	Credit Cards:	$
Gas	$	Visa Limit	$
Water / Sewer	$	MasterCard Limit	$
Trash	$	Discover Limit	$
Phone	$	Other Limit	$
Cable	$	Installment Loans	$
Auto Payments	$	Child Support	$
Auto Expenses	$	Miscellaneous Expenses	$
Insurance:	$		$
Auto Premium	$		$
Life Insurance	$		$
Health Insurance	$		$

OFFICE USE ONLY
Gross income_____
Net income_____
Total Expenses_____
Total Net income(loss)_____

To my knowledge the information provided above is true. I authorize a Credit Bureau Report to be secured by the Hospital or its agent to verify my financial standing.

_____ _____

PATIENT/GUARANTOR SIGNATURE ***DATE***

TRINITY HOSPITAL - Confidential Financial Assistance Statement Summary

Hospital: _____
Patient Name: _____ Patient Number: _____
Total Charges: _____ Date of Service: _____
__ Deceased __ Homeless Date of Assignment: (if applicable) _____

Coverage

To provide consideration for financial assistance, it is necessary that all other payer resources have been exhausted. Please identify that the patient has been screened, and deemed ineligible for the following potential programs:

θ Medicaid/Medi-Cal θ Disability θ Supplemental Security Income
θ Insurance Coverage θ Third Party Liability θ CCS/CDIC
θ County Program θ Victims of Violent Crimes θ Workers' Compensation
θ Medicare θ Diagnosis Specific Programs

If a partial payment has been made it is to be deducted from total discount recommended:
Amount paid: $_____ by whom _____

Income/Expense Verification

Please identify that income and expense has been verified.
☐ Income Verified. Source: _____
☐ Absence of income attestation. Completed by _____
☐ Statements of assets. (Bank statement copies, etc.)
☐ Mortgage/Rent Statements.
☐ Other living expenses. (Copies of utilities bills, Auto, Insurance)
☐ Patient Signature.
☐ Patient NET WORTH $ _____

Summary for Charity Care Consideration:

Percentage of FPG: %	**Eligible for write- off: YES____ No _____**	**Recommendation Amount:**
Eligible for Charity Care	**θ Yes**	**θ No**
Eligible for Reduced Payment Rate:	**θ Yes**	**θ No**

Submitted by: _____ (Print Name) _____ (Signature) _____ (Date)

Phone Number: _____ **Financial Counselor Signature:** _____

☐ Confidential Financial Statement
☐ Worksheet
☐ Supporting Documents
☐ Credit Bureau Report

Denied θ Yes θ No
Reason
_____
_____ **Denied**
_____**Date**_____