TAHOE FOREST HOSPITAL DISTRICT

Financial Assistance Application

INSTRUCTIONS

1. Please complete *all* areas on the attached application form. If any area does not apply to you, write N/A in the space provided.

2. Attach an additional page if you need more space to answer any question.

3. You *must* provide proof of income documents when you submit this application. The following documents are accepted as proof of income:

   If you filed a federal income tax return you must submit a copy of:
   a. Federal income tax return (Form 1040) from the most recent year. You must include all schedules and attachments as submitted to the Internal Revenue Service; Include Schedule C for self employed.

   If you did not file a federal income tax return, please provide the following:
   a. Two (2) most recent paycheck stubs; and
   b. A letter explaining why you do not file a federal income tax return.

   If you have no income, or proof of income documents, please provide a letter explaining how you support yourself/family.

4. Your application cannot be processed until *all* required information is provided.

5. It is important that you complete and submit the financial assistance application along with all required attachments within fourteen (14) days.

6. You *must* sign and date the application. If the patient/guarantor and spouse provide information, both *must* sign the application.

7. **If you have questions, please call your account representative:**
   Outpatient Services: 530-582-6256 Inpatient Services: 530-582-6215
   Self Pay Team-Last Name Begins with: A-F 530-582-3525
   G-O 530-582-3551
   P-Z 530-582-6206

8. **Send your completed application to:**
   Tahoe Forest Hospital District
   Patient Financial Services Department
   PO BOX 60901
   Truckee, CA 96160

   Or, In Person To:

   10955 Donner Pass Rd
   Truckee, CA 96161

Financial Assistance Application

PATIENT/ GUARANTOR NAME		SPOUSE NAME	
ADDRESS		Home PHONE	
		Work PHONE	

SOCIAL SECURITY NUMBER			
Patient/ Guarantor		Spouse	

FAMILY STATUS List all dependents that you support		
Name	Age	Relationship
1		
2		
3		
4		
5		
6		
7		
8		

EMPLOYMENT STATUS	
Patient/Guarantor Employer	Position
Contact Person	Telephone
Spouse Employer	Position
Contact Person	Telephone

Financial Assistance Application

INCOME		
	Patient/Guarantor	Spouse
1. Gross Wages & Salary/Year (before deductions)		
2. Self-Employment Income/Year		
3. Other Income:		
3. Interest & Dividends		
4. Real Estate Rentals & Leases		
5. Social Security		
6. Alimony		
7. Child Support		
8. Unemployment/Disability		
9. Public Assistance		
10. All Other Sources (attach list)		
Total Income (add lines 1 - 10 above)		

UNUSUAL EXPENSES	
Please provide information on any unusual expenses such as medical bills, bankruptcy, court judgments or settlement payments (attach list as needed).	
Description	Amount

By signing below, I/we declare that all information provided is true and correct to the best of my/our knowledge. I/we authorize Tahoe Forest Hospital District to verify any information listed in this application. We expressly grant permission to contact my/our employer.

_______________________________ ___________ _________________________ ___________
Signature of Patient/Guarantor Date Signature of Spouse Date

HOSPITAL USE ONLY
Application reviewed by:_____________________________ Date:__________________
Approved: __ Yes __No / Reason for denial____
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