



FINANCIAL ASSISTANCE APPLICATION

Fairchild Medical Center offers Financial Assistance to patients who cannot afford medically necessary hospital services. Financial Assistance is available to all regardless of immigration status.

Please select the program that you are applying for:

- Charity Care (Free Care)
- Discounted Payment/Payment Plan

NOTE: You may apply for both programs, if you qualify for Charity Care and the Discounted Payment, Fairchild Medical Center will apply the greater of the two discounts.

Type of Income	Documentation
Employment Income	Copy of recent federal income tax return (for calendar year of first bill or 12 months prior) or Recent paystubs (within 6 months before or after first billing date)
Self-Employment Income	Copy of recent federal income tax return (for calendar year of first bill or 12 months prior) or Recent paystubs (within 6 months before or after first billing date)
Social Security/Retirement	Copy of recent federal income tax return (for calendar year of first bill or 12 months prior) or Copy of Award Letter from Social Security stating monthly payment or Copy of monthly payment notification from Social Security Administration
Disability	Copy of recent federal income tax return (for calendar year of first bill or 12 months prior) or Copy of Award Letter stating disability payments or Copy of monthly notification from disability
Unemployment	Copy of recent federal income tax return (for calendar year of first bill or 12 months prior) or Copy of letter stating monthly award amount

Please return your completed application with all documentation in the enclosed self-addressed envelope within 14 days. If you have any questions, please contact one of our Financial Counselors at (530) 841-8537, option 2.



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Family Information: Please provide the names of all family members to be considered for financial assistance.

Last Name:	First Name:	Medical Record Number:
Last Name:	First Name:	Medical Record Number:
Last Name:	First Name:	Medical Record Number:
Last Name:	First Name:	Medical Record Number:

Applicant (Guarantor) Information: (Circle one)			
<u>Relationship to Patient</u>			
<input type="checkbox"/> Self <input type="checkbox"/> Spouse/Domestic Partner <input type="checkbox"/> Parent <input type="checkbox"/> Other			
Last Name:		First Name:	
Date of Birth:	No. of Dependents:	Ages of Dependents:	Phone:
Street Address, city, state, zip code:			
Employer:	Employers' address, city state, zip code:		
If you are not currently working, how long have you been unemployed:			
Co-Applicant (Guarantor) Information: (Circle one)			
<u>Relationship to Patient</u>			
<input type="checkbox"/> Self <input type="checkbox"/> Spouse/Domestic Partner <input type="checkbox"/> Parent <input type="checkbox"/> Other			
Last Name:		First Name:	
Date of Birth:	No. of Dependents:	Ages of Dependents:	Phone:
Street Address, city, state, zip code:			
Employer:	Employers' address, city state, zip code:		
If you are not currently working, how long have you been unemployed:			

Income Information:

Monthly Income Sources	Applicant	Co-Applicant	Combined Monthly Income
Employment Wages			
Self-Employment			
Unemployment			
Pensions/Retirement			
Workers Comp			
Social Security			
Disability			
Child Support			
Alimony			
Other Income			

Total Monthly Combined Income: \$

Total Number of People in Household:

If you do not have monthly income, please explain how you take care of your monthly expenses. Use additional page if necessary.

MONTHLY EXPENSES:

Mortgage/Rent:	Electricity:	Gas/Oil/Kerosene (heating):
Water/Sewer/Garbage:	Phone/Cable/Internet:	Medical/Dental Expenses:
Prescriptions:	Medical Insurance:	Vehicle Payment:
Vehicle Insurance:	Vehicle Gas:	Vehicle Maintenance:
Homeowners/Renters Insurance:	Child Support:	Childcare:
Laundry:	Other:	Other:

CERTIFICATION:

I certify that the information listed on this application is true and correct to the best of my knowledge. I understand that the information provided is to be used to determine my ability to pay for services at Fairchild Medical Center.

I understand that all the information provided is subject to verification. I also release Fairchild Medical Center and any party from liability from any acts, communications, or disclosures which are made pursuant to such an investigation. I understand that if the information which I submit is determined to be false, such a determination will result in a denial of this application, and I will be liable for all charges.

Signature (Patient/Applicant)

Date

Signature (Co-Applicant)

Date

For Office Use Only:

Process Date: _____
Date: _____

Approved Denied

Expiration

Processed by: _____

Approved % Rate _____