



Charity Care/Discount Application

I certify that all statements made in this application are true and complete. You are hereby authorized to check my credit history or employment references in order to evaluate this application for Charity Care or Discount financial assistance consideration.

Signature _____

Date _____

In order for this application to be considered for assistance under the Charity Care/Discount Policy the following documents are required if applicable to you.

- Copy of Charity Care Assistance Application Form
- A copy of the tax return for the 12 months in which the first billing occurred, **OR**
- A copy of a recent pay stub

Please be advised that this is not a guarantee that Charity Care/Discount assistance will be awarded and payment should continue on a regular basis until a determination has been made. Your application and the information provided will be reviewed and verified and a decision will be provided to you in writing. Incomplete applications or applications without complete documents will be denied.

In you have any questions, please do not hesitate to contact the Business office at 530-225-8700.

Return by:

Account # _____ Balance: _____



Charity Care Discount Application

PATIENT NAME _____ SPOUSE/DOMESTIC PARTNER _____
ADDRESS _____ PHONE _____
ACCOUNT# _____ SS# _____

FAMILY STATUS: *List all dependents that you support – add another sheet if necessary*

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

EMPLOYMENT AND OCCUPATION

Employer _____
Position: _____

Contact Person & Telephone:

If Self-Employed, Name of
Business: _____

Spouse/Domestic Partner Employer _____
Position: _____

Contact Person &
Telephone: _____

If Self-Employed, Name of
Business: _____

CURRENT MONTHLY INCOME

All wages or Income from Employment, including self
employment _____
(Attach copies of check stubs or W-2's)

Additional: Other Income:	Patient	Spouse/Domestic Partner
Social Security	_____	_____
Other (Specify)	_____	_____

By signing this form I agree to allow Patients' Hospital of Redding to verify the above information including credit history and I may be required to submit proof of the information I am providing. Failure to complete the form or sign it will result in denial of benefits under this program:

Signature of Patient

or Guarantor:_____ ***Date:***_____

Signature of Spouse/Domestic

Partner:_____ ***Date:***_____

NEW: 02/07
REVISED: 01/08, 08/07/08, 12/11, 1/25, 6/26
M:\COMMON\FORMS\BUSINESS OFFICE\CHARITY CARE DISCOUNT APPLICATION.