Mad River Community Hospital

FINANCIAL SCREENING APPLICATION

DATE OF APPLICATION: _____

Please fill out all information completely. Please print all information.

PLEASE NOTE
◆ We cannot guarantee that you will qualify for financial assistance, even if you apply. ◆ Once you send in your application, we may ask for additional information or proof of income

FAMILY INFORMATION - Please provide names of all people to be considered for financial assistance. *(Attached additional page if more space needed)*			
Last Name	First Name	Middle Initial	Date of Birth
Last Name	First Name	Middle Initial	Date of Birth
Last Name	First Name	Middle Initial	Date of Birth

** If the applicant is a minor, please list parent(s)/guardians(s) as applicant and co-applicant*

APPLICANT (GUARANTOR) INFORMATION			
Relationship to Patient: ☐ Self ☐ Spouse/Domestic Partner ☐ Parent ☐ Other			
Maritial Status: ☐ Single ☐ Married ☐ Domestic Partner ☐ Divorced ☐ Separated ☐ Widow			
Last Name	First Name	Middle Initial	Date of Birth
No. of Dependents *(Not including self and co-applicant)*		Age of Dependents	
Street Address	City	State	Zip Code
Current Employer	Street Address		Position
Home Phone	Cell Phone	* If you are not working, how long have you been unemployed?	

CO-APPLICANT INFORMATION

Relationship to Patient:	☐ Spouse/Domestic Partner		☐ Parent
Last Name	First Name	Middle Initial	Date of Birth

No. of Dependents *(Not including self and co-applicant)*	Age of Dependents

Street Address	City	State	Zip Code

Current Employer	Street Address	Position

Home Phone	Cell Phone	* If you are not working, how long have you been unemployed?

OTHER COVERAGE - All answers pertain to the patient

Does the patient have health insurance? ☐ Yes ☐ No
**If yes, please provide the following:*

Health Insurance Name	Insurance Phone Number

Subscriber Name	Identification Number

Effective Date	Group/Employer Name	Group Number

Is the patient eligible for a state medical assistance program? ☐ Yes ☐ No
** If yes, please provide the follwing:*

Name of Program	County	Identification Number

Is the patient a Victim of Crime? ☐ Yes ☐ No
** If yes, please provide the following:*

Name of Case Worker	Case Worker Phone Number

Claim or Case Number

Is the patient being treated for illness or injuier casued by a Third Party Liability such as an Auto Insurance Company? ☐ Yes ☐ No **If yes, please provide the following:*	
Name of Auto Insurance or Attorney	Auto Insurance or Attorney Phone Number
Injury Date	Claim or Case Number
Is the patient being treated for injuries covered by Workers Compensation? **If yes, please provide the follwing:* ☐ Yes ☐ No	
Name of Work Comp Carrier	Injury Date
Adjusters Name	Adjusters Phone Number
Claim or Case Number	

INCOME INFORMATION			
Monthly Income Sources	Applicant	Co-Applicant	Combined Income
Employement Income	$	$	$
Social Security	$	$	$
Disability	$	$	$
Unemployment	$	$	$
Rental Property Income	$	$	$
Investment Income	$	$	$
Other	$	$	$
	Total Combined Monthly Income		$

SIGNATURE			
By signing this form I attests that all information provided in both ture and accurate.			
Applicant	Date	Co-Applicant	Date
Return Completed application to: Fax: 707-825-8285 Email: collections@madriverhospital.com		Mad River Community Hospital Attnetion: Patient Accounting PO Box 1115 Arcata, CA 95518	

FINANCIAL ASSISTANCE APPLICATION INSTRUCTIONS

This is the application for financial assistance, also known as charity care, at Mad River Community Hospital. You may qualify for financial assistance based on your family size and income, even if you have health insurance. Financial Assistance may not cover all health care costs, including services provided by other organizations. Assistance is granted if you meet the financial assistance guidelines which includes if your household income is 400% or less of the Federal Poverty Level.

Required in order for your application to be procesed:

- Provide information about your family; fill in the number of family members in your household (family includes people related by birth, marriage, or adoption whol ive together)
- Provide information about your familys gross monthly income (income before taxes and deductions)
- Attach additonal information if needed
- Sign and date the form

Mad River Community Hospital will uphold the confidentiality of each patient. Any information submitted for consideration of financial assistance will be treated as protected health information under the Health Insurance and Accountability Act (HIPAA) and will not be sued for collections activities.

For more information regarding assistance or if you need help completing the application, please contact Credit and Collections. You may obtain help for any reason, including disability and language assistance.

Mad River Community Hospital	Phone: (707) 826-8260
Credit and Collections Department	M-F 8:30AM - 4:30PM
3800 Janes Rd	collections@madriverhospital.com
Arcata, CA 95521	Fax: (707) 826-8285

Every reasonable effort will be made to process your application promptly. Once your application has been reviewed you will receive a letter confirming the outcome.

IMPORTANT INFORMATION REQUIRED WITH APPLICATION

Proof of Income: Please provide any relevant documentation that applies to your current financial situation. Failure to submit the required suppporting documentation may delay the processing of your application and may further result in denial of financial assistance. The list below outlines the documentation that is required for consideration of MRCH Financial Assistance Charity Care.

Type of Income	Required documentation
Employment Income	◆ Copy of individual tax return (Form 1040, Page 1 & 2 only) for current tax year *(If claiming dependents, tax return is required)* or ◆ Copy of two most recent consecutive paystubs (for applicant and co-applicant, if applicable)
Self-Employment	◆ Copy of individual tax return (Form 1040, Page 1 & 2 only) for current tax year
Social Security / Retirement	◆ Copy of individual tax return (Form 1040, Page 1 & 2 only) for current tax year or ◆ Copy of Award Letter from Social Security Administration stating monthly payment or ◆ Copy of monthly payment notification or Pension award letter
Unemployment	◆ Copy of individual tax return (Form 1040, Page 1 & 2 only) for current tax year or ◆ Copy of Award Letter from unemployment stating daily, weekly, or monthly benefit amount
Disability	◆ Copy of individual tax return (Form 1040, Page 1 & 2 only) for current tax year or ◆ Copy of Award Letter from disability stating monthly disability payment
Rental Property Earned Income	◆ Copy of individual tax return (Schedule 1 Form)
Student - Proof of Enrollment	◆ Copy of current quarter/semester registration/enrollment
Sustainment Letter	◆ Letter/e-mail from applicant explaining how monthly expenses are supported (if no income reported)