MOUNTAIN COMMUNITIES HEALTHCARE DISTRICT (MCHD)
FINANCIAL ASSISTANCE FOR CHARITY AND DISCOUNT CARE APPLICATION

Charity and Discount Information

It is the policy of MCHD to provide essential services regardless of the patient's ability to pay. MCHD offers discounts based on family size and annual income. Patients who only apply for discount payment program eligibility may receive less financial assistance than what may be available to them under the charity care program.

If approved, charity or discounts will apply to all services at our clinics, or our hospital, including emergency physicians. Eligible Charges exclude, send-out diagnostic testing, and specialty services. Most healthcare providers have a financial assistance program. You must request financial assistance directly with those providers. You must complete this form every 12 months or if your financial situation changes.

Please complete the following information and return to the front desk of any of MCHD's facilities, or to MCHD's Financial Counselor, located at Trinity Hospital, 60 Easter Avenue, Weaverville, CA 96093, or mail to Trinity Hospital: Attention Financial Counselor at PO Box 1229, Weaverville, CA. 96093.

NAME				
STREET	CITY	STATE	ZIP	Phone

Please list all household members, their age and their relationship to the patient.

	Name	Age	Relationship	Dependent (yes or no)	Disabled (yes or no)
SELF					
OTHER					
OTHER					
OTHER					
OTHER					
OTHER					

EMPLOYMENT AND OCCUPATION

Employer: _____ Position: _____

Contact Person & Telephone: _____

If Self-Employed, Name of Business: _____

IMPORTANT: Please attach a copy of a recent tax return or recent pay stubs.*

Source	Self	Other	Total
Gross wages, salaries, tips, etc.			
Income from business and self-employment			
Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, veterans' payments, survivor benefits, pension or retirement income			
Other:			
Total Income			

If you have other insurance coverage, such as Medicare, Medi-Cal, VA or Third-Party Insurance, Please attach a copy of the insurance card (MCHD can make a copy for you).

Insurance name: _____ Insurance ID: _____

If you have low or inadequate insurance, you may qualify for Medi-Cal, Covered California or other government assistance programs. Would you like assistance with these? Yes _____ No _____

I certify that the family size, income, and insurance information shown above is correct. I also give permission to use the above information to verify income.

Name Print: _____ Signature: _____ Date: _____

Help Paying Your Bill

There are free consumer advocacy organizations that will help you understand the billing and payment process. You may call the Health Consumer Alliance at 888-804-3536 or go to healthconsumer.org for more information. You may find more information on MCHD's Pricing Transparency website www.mcmedical.org/price-transparency

Hospital Bill Complaint Program

The Hospital Bill Complaint Program is a state program, which reviews hospital decisions about whether you qualify for help paying your hospital bill. If you believe you were wrongly denied financial assistance, you may file a complaint with the Hospital Bill Complaint Program. Go to HospitalBillComplaintProgram.hcai.ca.gov for more information and to file a complaint.

Required Application Documents

For patients applying for either charity care or discount payment program eligibility, the healthcare facility may only request recent paystubs or income tax returns for documentation of income. The healthcare facility may accept other forms of documentation of income but shall not require such other forms.

***Recent tax returns** are tax returns which document a patient's income for the year in which the patient was first billed or 12 months prior to when the patient was first billed. **Recent paystubs** are paystubs within a 6-month period before or after the patient is first billed by the hospital, or in the case of preservice, when the application is submitted.

OFFICE USE ONLY

ELIGIBILITY DETERMINATION FOR FINANCIAL ASSISTANCE FOR CHARITY CARE

NAME				
STREET	CITY	STATE	ZIP	Phone

Verification Checklist	Date
Date completed application received with proof of income.	
If other proof of income was used, what was used	
Application approved for charity?	
Application approved for discount program, % discount approved:	
Application denied for charity, reason:	
Application denied for discount, reason:	
Eligibility Determination Letter sent to patient with the following: 1) A statement of the determination for charity care 2) A statement of the determination for discount care 3) If the patient was denied, the reason 4) If the patient was approved, an explanation of the reduced bill and instructions on how the patient may obtain additional information 5) Name of the office, contact name, and contact information where the patient may appeal the hospital's decision. 6) Information on Bill Complaint Program 7) Information on Health Consumer Alliance, including the following statement: **Help Paying Your Bill** There are free consumer advocacy organizations that will help you understand the billing and payment process. You may call the Health Consumer Alliance at 888-804-3536 or go to healthconsumer.org for more information.	