Patients' Hospital of Redding

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 prior years tax return
- A copy of a current pay stub
- A copy of social security, disability or unemployment checks or awards

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:_____

PATIENTS' HOSPITAL of Redding

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
M:\COMMON\FORMS\BUSINESS OFFICE\CHARITY CARE DISCOUNT APPLICATION.