Dear Patient,

You have requested financial assistance for one or more accounts with Plumas District Hospital. Please complete the attached application and submit with the required documentation listed below for review to determine the extent to which you qualify for our Discount Payment Program or Charity Care.

Our Patient Financial Counselors are available for personal assistance by appointment. During this time, they can screen and assist with finding the best resolution for your individual needs. Additionally, they are able to assist patients in applying for Medi-Cal and other insurance plans through Covered California.

It is our intent at Plumas District Hospital to help you through this process and find the best solution for you.

Please note the following information:

- If assistance if needed to complete this application, please contact our Patient Financial Counselor to schedule an appointment.
- All properly submitted applications will be processed within 10 business days of receipt. A final letter of determination will be provided.
- Any incomplete applications will be returned upon receipt with a letter advising what information is needed in order to process the application.
- Any application submitted for Charity Care consideration that does not qualify will automatically be considered for the Discount Payment Program, a separate application is not necessary.

Return your completed application along with all supporting documentation within 30 days of receipt of the application. Applications may be mailed, faxed, or emailed to the following:

Plumas District Hospital
Attn: Patient Financial Counselor
1065 Bucks Lake Road
Quincy, CA 95971

Fax: 530-283-7404, attention: Patient Financial Counselor
Email: FinCounselors@pdh.org

Thank you for choosing Plumas District Hospital for your health care needs. We look forward to assisting you further.

Best Regards,
Patient Financial Counselors
(530) 283-7400

Financial Assistance Application

I am applying for: ☐ Discount Payment Program ☐ Charity Care

Responsible Party Information:

Last Name	First Name	Social Security #	Date of Birth

Home (Physical Address	Mailing Address	City	State/Zip Code

Home phone #	Alternate/Cell Phone #

Employer Name	Job Function/Title	Employer Phone #

Gross Annual Income	Employer's address: Street, City, State, Zip

Spouse's name	Social Security #	Date of Birth

Employer Name	Job Function/Title	Employer Phone #

Gross Annual Income	Employer's address: Street, City, State, Zip

People in Household

	Name	Relationship to Patient	Date of Birth	Employer	Employer Telephone
1					
2					
3					
4					
5					
6					

Income Information

In order to determine the extent of your eligibility for the Discount Payment Program or Charity Care, please complete the required sections below. Please note different information is required for each program. Patients are encouraged to apply for both programs.

For patients applying only for Discount Payment Program eligibility, only recent paystubs or income tax returns are required for documentation of income. Patients that only apply for Discount Payment Program eligibility may receive less financial assistance than what may be available to them under the Charity Care Program.

Monthly Income: Required for Discount Payment Program

Job Income:	$_____	*Required Documentation*
Spouse Job Income:	$_____	Only ONE of the following:
Business Income:	$_____	☐ All paystubs from the last 90 days
Rental Income:	$_____	☐ Copy of the most recent filed tax return
Interest/Dividend Income:	$_____	☐ If no income, please attach a signed letter
Alimony or Support Income:	$_____	stating circumstances
Other Income	$_____	
Total Monthly Income:	$_____	

Monthly Income: Required for Charity Care Program

Job Income:	$_____	*Required Documentation*
Spouse Job Income:	$_____	One or more of the following:
Business Income:	$_____	☐ All paystubs from the last 90 days
Rental Income:	$_____	☐ Copy of the most recent filed tax return
Interest/Dividend Income:	$_____	☐ Most current W-2 for all working adults
Alimony or Support Income:	$_____	☐ Social Security Statement
Other Income	$_____	☐ If no income, please attach a signed letter
Total Monthly Income:	$_____	stating circumstances

By signing below you agree to be considered for PDH Discount Payment or Charity Care Program. Additionally, you certify that all of the statements and information provided on this application are true and complete to the best of your knowledge. Should it be determined that the information you provided is incomplete or false, any discount applied may be reversed and payment in full may be expected from you. By signing below, you authorize PDH to check references and credit history in order to determine eligibility for Discount Payment or Charity Care consideration.

You further agree by signing below, that if you receive payment from an insurance company, workers' compensation plan, or any other third party, to inform the hospital of any such payment. Plumas District Hospital retains the right to collect the original, full billed amount for rendered services should a third party provide you with payment.

Signature of Applicant Date