Mountain Communities Healthcare District
60 Easter Avenue
Weaverville, CA 96093
(530)-623-5541

# APPLICATION FOR FINANCIAL ASSISTANCE
## (Charity and Discount Program)

☐ Attach your most recent income tax returns ***OR*** your most recent 3 month's pay stubs.

**PATIENT NAME** _____ **SPOUSE** _____

**ADDRESS** _____ **PHONE** _____

**ACCOUNT #** _____ **SSN** _____

**FAMILY STATUS**: List any spouse, domestic partner, or children under the age of 21. If patient is a minor, list all parents, caretaker relatives, and siblings under 21.

| Name | Age | Relationship |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**EMPLOYMENT AND OCCUPATION**

Employer: _____ Position: _____

Contact Person & Telephone: _____

If Self-Employed, Name of Business: _____

| **CURRENT MONTHLY INCOME** | **Patient** | **Other Family** |
|---|---|---|
| Gross Pay (Before Deductions) | _____ | _____ |
| Add: Income - Operating Business (if Self-Employed) | _____ | _____ |
| Add: Other Income: | | |
| Interest and Dividends | _____ | _____ |
| From Real Estate or Personal Property | _____ | _____ |
| Social Security | _____ | _____ |
| Other (Specify): | _____ | _____ |
| Alimony or Support Payments Received | _____ | _____ |
| Subtract: Alimony, Support Payments Paid | _____ | _____ |
| Equals: Current Monthly Income | _____ | _____ |

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**FAMILY SIZE**

Total Family Members _____

**AMOUNT OF ALL FAMILY MEDICAL BILLS (Last 12 Months):** _____

(Add patient, parents (for minor pa

| | Yes | No |
|---|---|---|
| Do you have health insurance? | ☐ | ☐ |
| Do you have other insurance that may apply (i.e., auto policy)? | ☐ | ☐ |
| Were your injuries caused by a third party (i.e., car accident, slip, or fall)? | ☐ | ☐ |

By signing this form, I agree to allow Trinity Hospital to check employment for the purporse of determining my eligibility for a financing discount. I understand that I may be required to provide proof of the information I am providing.

_____ _____

**(Signature of Patient or Guarantor)** **(Date)**

_____ _____

**(Signature of Spouse)** **(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.

## 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.