Eastern Plumas Health Care
"People Helping People"

500 East First Ave.
Portola, CA, 96122
Phone: (530) 832-6568
Fax: (530) 832-1105

Dear Patient,

At Eastern Plumas Health Care we are committed to helping the needs of our community. Attached you will find the Charity Care Application, please fill out all pages completely. In addition, please provide the following accompanying information with your application:

a) Copies of your prior three months bank statements.
b) Copy of your last Federal Income Tax return filed.
c) Copies of your prior three months' paycheck stubs.

For us to process your request we will need the enclosed form completed and returned to our business office within 30 business days from time of service**.** Upon receipt of the above information, you will be notified of our decision. Should you require further clarification or have any questions, please contact me at (530) 832-6568.

Sincerely,
April Shepherd
Patient Financial Service Coordinator
Eastern Plumas Health Care

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CHARITY CARE FINANCIAL STATEMENT

Date of Request: _____ Birthdate: _____

Patient's Name: _____ Telephone No.: _____

Social Security Number: _____

Address: _____

Account #: _____ Dates of Service: _____

Marital Status: _____ Name of Spouse: _____

Employer: _____ Last Day Worked: _____

Spouse's Employer: _____ Last Day Worked: _____

Do you have? Medicaid _____Medicare _____Other Insurance _____

Gross Annual Family Income: Self: $_____

Spouse: $_____

Other: $_____

Total: $_____

Number of Dependents Supported on Income (Include Self): _____

Provider of Financial Information (If other than patient or guarantor):

Name: _____

Address: _____

DO NOT COMPLETE (To be completed by Hospital Personnel only).

This document was received on: _____

By: _____ Title: _____

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CHARITY CARE FINANCIAL STATEMENT

Patient Full Name	Birthdate	Social Security Number
Physical Address		
Mailing Address (if different)		Telephone Number
Patient Employer Name		
Employer Address		Employer Phone Number
Patients Previous Employer (if within two Years	Position	Years of Employment?
Salary, Wages, or Commissions Earned		

Weekly:	Bi-Weekly:	Semi-Monthly:	Monthly:
Other Income Per Month		Source of Other Income	

Spouse Full Name	Birthdate	Social Security Number
Spouse Employer Name		Employer Phone Number
Employer Address		
Numbers of Members in Family		

Name	Relationship	Age	Gender

Bank Name		Branch	
Checking Account Number		Saving Account Number/ Loan Number(s)	
Do you Rent or Own a Home?		Monthly Payment	
Description of Real Estate Owned	Value	Amount Owed	
Make, Model and Year of Vehicle Owned		Amount Owed	
Make, Model and Year of Vehicle		Amount Owed	
List All Debts (attach additional sheets if necessary)			
Creditor	Address	Balance Owing	Monthly Payment
Creditor	Address	Balance Owing	Monthly Payment
Creditor	Address	Balance Owing	Monthly Payment

I UNDERSTAND THAT THE INFORMATION WHICH I SUBMIT IS SUBJECT TO VERIFICATION BY EASTERN PLUMAS HEALTH CARE AND SUBJECT TO REVIEW BY GOVERNMENTAL AGENCIES. I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT.

Signature: _____ Date: _____Time_____

Printed Name: _____