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 Form
- A copy of the prior years tax return
- Current Bank Statement
- A copy of a current pay stub
- A copy of social security, disability or unemployment checks or awards
- A copy of a state AHCCS/MediCal Decision/Denial Notice. Any notice of action stating a failure to provide information or failure to participate in the interview will not be accepted in consideration of this application.

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*

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
Wages or Income from Employment_____
(Attach copies of check stubs or W-2's)

Additional: Other Income:	Patient	Spouse/Domestic Partner
Interest/Dividends	_____	_____
Real Estate/Property	_____	_____
Social Security	_____	_____
Other (Specify)	_____	_____
Alimony or Support	_____	_____
Subtract: Alimony/Support Paid	_____	_____
Equals: Current Monthly Income	_____	_____

Total Current Monthly Income
(Patient + Spouse/Domestic Partner) _____

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
M:\COMMON\FORMS\BUSINESS OFFICE\CHARITY CARE DISCOUNT APPLICATION
C/R: CHARITY CARE/DISCOUNT POLICY