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 one of our Patient Financial Counselors 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 <u>all supporting documentation</u> 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: 530-283-7946, attention: Patient Financial Counselor
Email: FinancialCounselor@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- 7997 or
(530) 283- 7927

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 and Asset 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.

Monthly Income: Required for Discount Payment Program and Charity Care

Job Income: $_____
Spouse Job Income: $_____
Business Income: $_____
Rental Income: $_____
Interest/Dividend Income: $_____
Alimony or Support Income: $_____
Other Income: $_____
Total Monthly Income: $_____

Required Documentation
One or more of the following:

- ❑ All paystubs from the last 90 days
- ❑ Most current W-2 for all working adults
- ❑ Copy of the most recent filed tax return
- ❑ Social Security Statement
- ❑ If no income, please attach a signed letter stating circumstances.

Current Monthly Essential Living Expenses: Required for Discount Payment Plan

Mortgage/Rent Payment: $_____
Insurance Premiums: $_____
(health, auto, home)
Utilities: $_____
(gas, electricity, water, phone)
Automobile Payment(s): $_____
Food: $_____
Other _____: $_____
Other _____: $_____
Total Monthly Essential Living Expenses: $_____

Required Documentation
One or more of the following:

- ❑ Proof of amount of most recent mortgage/ rent paid
- ❑ Most current statements for any expense listed/claimed on this application
- ❑ Receipts/proof of payment for amounts paid for food/medical expenses paid in the past 12 months *(an average will be determined for application/eligibility purposes).*

Qualified Monetary Assets: Required for Charity Care

Checking Account(s): $_____
Savings Account(s): $_____
Stock, Bonds and CDs: $_____
Other _____: $_____
Total Qualified Monetary Assets: $_____

Required Documentation
One or more of the following:

- ❑ Most recent bank statements
- ❑ Most recent Quarterly Statement for stock(s), bond(s), or CD(s)
- ❑ Other: Most recent statement showing total monetary worth of asset

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 Plumas District Hospital District 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