## MOUNTAIN COMMUNITIES HEALTCARE DISTRICT - Confidential Financial Statement (Application)

ResPonsible Party   Name	Patient Name			DOS	DOS:				
Name   Marital Status   Social Security Number	Patient Number			Confidential Financial Statement (Application)					
Street Address, City, State, Zip	RESPONSIBLE PARTY								
Employers Name and Address (If Unemployed –How Long)  Position / Title  Monthly income – Gross  Monthly income – Net  Length of current employment  SPOUSE  Name  Employer Name and Address  Position / Title  Monthly income – Gross  Monthly income – Net  Length of current employment  Employer Name and Address  Position / Title  Monthly income – Gross  Monthly income – Net  Length of current employment  Length of current employment  Do Any Other Persons Contribute? If Yes, Amount:  Name & Year of Birth of all persons in Household  INCOME PER MONTH & ASSETS  Dividends, Interest  S  Child Support / Allimony  S  Social Security  S  Child Support / Allimony  S  Public Assistance / Food Stamps  Rental income  S  Social Security  S  Grants  S  Unemployment Compensation  S  IRA  S  Workers' Compensation  S  EXPENSES PER MONTH  Mortgage / Rent  Mortgage / Rent  Balance: S  Medical / Dental  S  Own Home? (Yes/No)  Doctor - Name  Prood  S  Doctor - Name  S  Grast  S  Water / Sower  S  Water / Sower  S  Master Cate  S  Mater Cate  S  Master Cate  S  Mater S  Master Cate  S  Mater S  Master Cate  S  Mater Cate  S  Mater S  Master Cate  S  Master Cate  S  Master Cate  S  Mater Cate  S  Mater Cate  S  Mater Cate  Ton y knowledge the information provided above is run. I authorize a Credit Bureau Report to be secured by the fricipation to sagent to verify my financiaus attending.	Name			Mari	tal Status		Social Security	Number	
Employers Name and Address (If Unemployed –How Long)  Position / Title  Monthly income – Gross  Monthly income – Net  Length of current employment  SPOUSE  Name  Employer Name and Address  Position / Title  Monthly income – Gross  Monthly income – Net  Length of current employment  Employer Name and Address  Position / Title  Monthly income – Gross  Monthly income – Net  Length of current employment  Length of current employment  Do Any Other Persons Contribute? If Yes, Amount:  Name & Year of Birth of all persons in Household  INCOME PER MONTH & ASSETS  Dividends, Interest  S  Child Support / Allimony  S  Social Security  S  Child Support / Allimony  S  Public Assistance / Food Stamps  Rental income  S  Social Security  S  Grants  S  Unemployment Compensation  S  IRA  S  Workers' Compensation  S  EXPENSES PER MONTH  Mortgage / Rent  Mortgage / Rent  Balance: S  Medical / Dental  S  Own Home? (Yes/No)  Doctor - Name  Prood  S  Doctor - Name  S  Grast  S  Water / Sower  S  Water / Sower  S  Master Cate  S  Mater Cate  S  Master Cate  S  Mater S  Master Cate  S  Mater S  Master Cate  S  Mater Cate  S  Mater S  Master Cate  S  Master Cate  S  Master Cate  S  Mater Cate  S  Mater Cate  S  Mater Cate  Ton y knowledge the information provided above is run. I authorize a Credit Bureau Report to be secured by the fricipation to sagent to verify my financiaus attending.	Street Address, City, State, Zip			How long at this address		Home Phone	-		
Position / Title   Monthly income – Gross   Monthly income – Net   Length of current employment	Employers Name and Address (I	f Unemployed	d –How Long)				Business Phone	<del></del>	
SPOUSE   Name   Social Security Number	<u> </u>				Monthly in	scomo Not			
Social Security Number		,				Come – Net	Length of curren		
Employer Name and Address  Position / Title  Monthly income – Gross  Monthly income – Net  Length of current employment  DePENDENTS  Name & Year of Birth of all persons in household  INCOME PER MONTH & ASSETS  Dividends, Interest  \$ Child Support / Alimony  \$ Rental Income  \$ Social Security  \$ Grants  \$ Unemployment Compensation  \$	SPOUSE								
Department	Name						Social Security	Social Security Number	
DEPENDENTS  Name & Year of Birth of all persons in household  Name & Year of Birth of all persons in household  Name & Year of Birth of all persons in household  Name & Year of Birth of all persons in household  Name & Year of Birth of all persons in household  Name & Year of Birth of all persons in household  Name & Year of Birth of all persons in household  Name & Year of Birth of all persons in household  Name & Year of Birth of all persons in household  Name & Year of Birth of all persons in household  Name & Year of Birth of all persons in household  Name & Service  Service  Name & Service  Nam	Employer Name and Address						Business Phone	)	
Name & Year of Birth of all persons in household   Total Number of Persons in Household   Do Any Other Persons Contribute? If Yes, Amount: Yes/No Amount   Y	Position / Title		Monthly income – Gross		Monthly income – Net		Length of currer	Length of current employment	
Income   I	DEPENDENTS				•		<u>.</u>		
Dividends, Interest   S									
Public Assistance / Food Stamps   S	INCOME PER MONTH &	ASSETS							
Social Security   \$   Grants   \$	Dividends, Interest \$				Child Su	ipport / Alimony		\$	
Unemployment Compensation   \$   IRA   \$   \$   Workers' Compensation   \$   Other   \$   \$   \$   \$   \$   \$   \$   \$   \$	Public Assistance / Food Stamps \$			Rental Income				\$	
Workers' Compensation   \$	Social Security \$			Grants				\$	
Savings   \$   \$	Unemployment Compensation \$			IRA				\$	
Mortgage / Rent \$ Balance: \$   Medical / Dental   \$	Workers' Compensation \$				Other \$			\$	
Mortgage / Rent \$ Balance: \$   Medical / Dental   \$	Savings \$				\$				
Doctor - Name   S	EXPENSES PER MONTH	1							
Food	Mortgage / Rent \$ Balance: \$				Medical / Dental \$				
Utilities:  Doctor – Name  Electric  \$ Credit Cards: \$  Gas  \$ Visa Limit \$  Water / Sewer \$ MasterCard Limit \$  Trash \$ Discover Limit \$  Phone \$ Other Limit \$  Cable \$ Installment Loans \$  Auto Payments \$ Child Support \$ Miscellaneous Expenses  Insurance: \$ Miscellaneous Expenses  For Health Insurance \$ To my knowledge the information provided above is true. I authorize a Credit Bureau Report to be secured by the Hospital or its agent to verify my financial standing.  PATENTICUARDANTOR SIGNATURE  PATENTICAL SIGNATURE  PAT					Doctor – Name				
Electric   \$   Credit Cards:   \$	Food \$			Doctor – Name			\$	\$	
Gas \$ Visa Limit \$ Water / Sewer \$ MasterCard Limit \$ Trash \$ Discover Limit \$ Discover Lim	Utilities:			Doctor – Name			\$	\$	
Water / Sewer \$ MasterCard Limit \$ Trash \$ Discover Limit \$ Phone \$ Other Limit \$  Cable \$ Installment Loans \$  Auto Payments \$ Child Support \$  Auto Expenses \$ Miscellaneous Expenses \$  Insurance: \$ \$  Auto Premium \$ \$  Life Insurance \$ \$  Health Insurance \$ \$  OFFICE USE ONLY Gross income	Electric \$			Credit Cards:			\$		
Trash \$ Discover Limit \$ Phone \$ Other Limit \$ Cable \$ Installment Loans \$ Auto Payments \$ Child Support \$ Auto Expenses \$ Miscellaneous Expenses \$ Insurance: \$ \$ Auto Premium \$ \$ Life Insurance \$ \$ Health Insurance \$ \$ OFFICE USE ONLY Gross income	Gas \$			Visa Limit			\$		
Phone \$ Other Limit \$ Cable \$ Installment Loans \$ Auto Payments \$ Child Support \$ Auto Expenses \$ Miscellaneous Expenses \$ Insurance: \$ \$ Auto Premium \$ \$ Life Insurance \$ \$ Health Insurance \$ \$ OFFICE USE ONLY Gross income	Water / Sewer \$			MasterCard Limit			\$		
Cable \$ Installment Loans \$ Auto Payments \$ Child Support \$ Auto Expenses \$ Miscellaneous Expenses \$ Insurance: \$ \$ Auto Premium \$ \$ Life Insurance \$ \$ Health Insurance \$ \$ OFFICE USE ONLY Gross income	Trash \$			Discover Limit			·		
Auto Payments \$ Child Support \$ Auto Expenses \$ Miscellaneous Expenses \$ Insurance: \$ \$ Auto Premium \$ \$ Life Insurance \$ \$ Health Insurance \$ \$ OFFICE USE ONLY Gross income	Phone \$			Other Limit			\$		
Auto Expenses \$ Miscellaneous Expenses \$ Insurance: \$ \$ Auto Premium \$ \$ Life Insurance \$ \$ Health Insurance \$ \$  OFFICE USE ONLY Gross income	Cable			Installment Loans			·		
Insurance: \$ \$ \$ Auto Premium \$ \$ Life Insurance \$ \$ Health Insurance \$ \$  OFFICE USE ONLY Gross income				I I					
Auto Premium \$ \$  Life Insurance \$ \$  Health Insurance \$ \$  OFFICE USE ONLY Gross income Net income Total Expenses \$  NATIONAL PRANTOR SIGNATURE TO ATE				Misc					
Life Insurance \$ \$ \$ Health Insurance \$ \$  OFFICE USE ONLY Gross income				•					
Health Insurance \$  OFFICE USE ONLY Gross income				*					
OFFICE USE ONLY Gross income Net income Total Expenses  DATE									
Gross income secured by the Hospital or its agent to verify my financial standing.  Net income  Total Expenses  BATIENT/CUARANTOR SIGNATURE	Health Insurance	\$					\$		
Total Expenses	Gross income							Credit Bureau Report to be	
DATIENT/CHADANTOD SIGNATUDE DATE				-					
	Total Net income(loss)			PAT	TENT/GU	ARANTOR SIGNAT	JRE DATE	Ē	

## **TRINITY HOSPITAL - Confidential Financial Assistance Statement Summary**

Patient Name: Patient Number: Date of Service: Date of Assignment: (if applicable)   Patient Number:   Patient Number:	
Total Charges: Deceased Homeless Date of Service: Date of Service: Date of Assignment: (if applicable)   Coverage  To provide consideration for financial assistance, it is necessary that all other payer resources have been exhausted. Please identify the been screened, and deemed ineligible for the following potential programs: θ Medicaid/Medi-Cal θ Disability θ Supplemental Security Income θ Insurance Coverage θ Third Party Liability θ CCS/CDIC θ County Program θ Victims of Violent Crimes θ Workers' Compensation θ Medicare θ Diagnosis Specific Programs  If a partial payment has been made it is to be deducted from total discount recommended:	
To provide consideration for financial assistance, it is necessary that all other payer resources have been exhausted. Please identify the been screened, and deemed ineligible for the following potential programs:  θ Medicaid/Medi-Cal θ Disability θ Supplemental Security Income  θ Insurance Coverage θ Third Party Liability θ CCS/CDIC  θ County Program θ Victims of Violent Crimes θ Workers' Compensation  θ Medicare θ Diagnosis Specific Programs  If a partial payment has been made it is to be deducted from total discount recommended:	at the patient has
been screened, and deemed ineligible for the following potential programs:  θ Medicaid/Medi-Cal θ Disability θ Supplemental Security Income  θ Insurance Coverage θ Third Party Liability θ CCS/CDIC  θ County Program θ Victims of Violent Crimes θ Workers' Compensation  θ Medicare θ Diagnosis Specific Programs  If a partial payment has been made it is to be deducted from total discount recommended:	at the patient has
been screened, and deemed ineligible for the following potential programs:  θ Medicaid/Medi-Cal θ Disability θ Supplemental Security Income  θ Insurance Coverage θ Third Party Liability θ CCS/CDIC  θ County Program θ Victims of Violent Crimes θ Workers' Compensation  θ Medicare θ Diagnosis Specific Programs  If a partial payment has been made it is to be deducted from total discount recommended:	at the patient has
$\begin{array}{lll} \theta \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ $	
<ul> <li>θ County Program</li> <li>θ Victims of Violent Crimes</li> <li>θ Workers' Compensation</li> <li>θ Diagnosis Specific Programs</li> </ul> If a partial payment has been made it is to be deducted from total discount recommended:	
<ul> <li>θ Medicare</li> <li>θ Diagnosis Specific Programs</li> <li>If a partial payment has been made it is to be deducted from total discount recommended:</li> </ul>	
If a partial payment has been made it is to be deducted from total discount recommended:	
Income/Expense Verification	
Please identify that income and expense has been verified.  Income Verified. Source:	
Statements of assets. (Bank statement copies, etc.)	
Other living expenses. (Copies of utilities bills, Auto, Insurance)  Patient Signature.	
Patient NET WORTH \$	
Summary for Charity Care Consideration:	
Percentage of FPG: % Eligible for write- off: YES No Recommendation A	amount:
Eligible for Charity Care $\theta$ Yes $\theta$ No	
Eligible for Charity Care $\theta$ Yes $\theta$ No Eligible for Reduced Payment Rate: $\theta$ Yes $\theta$ No	,
Eligible for Reduced Payment Rate: θ Yes θ No	1
Eligible for Reduced Payment Rate: θ Yes θ No Submitted by:	
Eligible for Reduced Payment Rate: θ Yes θ No	(Date)
Eligible for Reduced Payment Rate: θ Yes θ No Submitted by:	(Date)
Eligible for Reduced Payment Rate: θ Yes θ No  Submitted by: (Print Name) (Signature)  Phone Number: Financial Counselor Signature:	(Date)
Eligible for Reduced Payment Rate: θ Yes θ No  Submitted by: (Print Name) (Signature)  Phone Number: Financial Counselor Signature:  Confidential Financial Statement Worksheet	(Date)
Eligible for Reduced Payment Rate: θ Yes θ No  Submitted by: (Print Name) (Signature)  Phone Number: Financial Counselor Signature:	(Date)
Eligible for Reduced Payment Rate: θ Yes θ No  Submitted by: (Print Name) (Signature)  Phone Number: Financial Counselor Signature:  Confidential Financial Statement Worksheet Supporting Documents Credit Bureau Report  Denied θ Yes θ No	(Date)
Eligible for Reduced Payment Rate: θ Yes θ No  Submitted by: (Print Name) (Signature)  Phone Number: Financial Counselor Signature:  Confidential Financial Statement Worksheet Supporting Documents Credit Bureau Report	(Date)
Absence of income attestation. Completed by      Statements of assets. (Bank statement copies, etc.)      Mortgage/Rent Statements.      Other living expenses. (Copies of utilities bills, Auto, Insurance)      Patient Signature.      Patient NET WORTH \$	