**MOUNTAIN COMMUNITIES HEALTCARE DISTRICT – Confidential Financial Statement (Application)**

| | |
|---|---|
| Patient Name_____ | **DOS:** _____ |
| Patient Number_____ | **Confidential Financial Statement (Application)** |

## RESPONSIBLE PARTY

| | | | |
|---|---|---|---|
| Name | | Marital Status | Social Security Number |
| Street Address, City, State, Zip | | How long at this address | Home Phone |
| Employers Name and Address (If Unemployed –How Long) | | | Business Phone |
| Position / Title | Monthly income – Gross | Monthly income – Net | Length of current employment |

## SPOUSE

| | | | |
|---|---|---|---|
| Name | | | Social Security Number |
| Employer Name and Address | | | Business Phone |
| Position / Title | Monthly income – Gross | Monthly income – Net | Length of current employment |

## DEPENDENTS

| | | |
|---|---|---|
| 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 _____ |

## INCOME PER MONTH & ASSETS

| | | | |
|---|---|---|---|
| Dividends, Interest | $ | **Child Support / Alimony** | $ |
| Public Assistance / Food Stamps | $ | Rental Income | $ |
| **Social Security** | $ | Grants | $ |
| Unemployment Compensation | $ | IRA | $ |
| Workers' Compensation | $ | Other | $ |
| Savings | $ | | $ |

## EXPENSES PER MONTH

| | | | |
|---|---|---|---|
| Mortgage / Rent $ | Balance: $ | Medical / Dental | $ |
| Own Home? (Yes/No) | | Doctor – Name | |
| Food | $ | Doctor – Name | $ |
| 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 | $ |
| Auto Expenses | $ | Miscellaneous Expenses | $ |
| Insurance: | $ | | $ |
| Auto Premium | $ | | $ |
| Life Insurance | $ | | $ |
| Health Insurance | $ | | $ |

OFFICE USE ONLY
Gross income_____
Net income_____
Total Expenses_____
Total Net income(loss)_____

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.

_____ _____

***PATIENT/GUARANTOR SIGNATURE*** ***DATE***

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

Hospital: _____
Patient Name: _____ Patient Number: _____
Total Charges: _____ Date of Service: _____
__ Deceased __ Homeless 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 that 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:
Amount paid: $_____ by whom _____

**Income/Expense Verification**

Please identify that income and expense has been verified.
☐ Income Verified. Source: _____
☐ 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 $ _____

**Summary for Charity Care Consideration:**

| | | |
|---|---|---|
| **Percentage of FPG: %** | **Eligible for write- off: YES____ No _____** | **Recommendation Amount:** |
| **Eligible for Charity Care** | **θ Yes** | **θ No** |
| **Eligible for Reduced Payment Rate:** | **θ Yes** | **θ No** |

**Submitted by:** _____ (Print Name) _____ (Signature) _____ (Date)

**Phone Number:** _____ **Financial Counselor Signature:** _____

☐ Confidential Financial Statement
☐ Worksheet
☐ Supporting Documents
☐ Credit Bureau Report

**Denied θ Yes θ No**
**Reason**
_____
_____ **Denied**
_____**Date**_____