MOUNTAIN COMMUNITIES HEALTHCARE DISTRICT (MCHD)

FINANCIAL ASSISTANCE APPLICATION

Discount Information

It is the policy of MCHD to provide essential services regardless of the patient's ability to pay. MCHD offers discounts based on family size and annual income.

Please complete the following information and return to the front desk or MCHD’s Financial Counselor, located at Trinity Hospital, 60 Easter Avenue, Weaverville, CA 96093 to determine if you or members of your family are eligible for a discount.

The discount will apply to all services received at this clinic or emergency room, but not those services or equipment purchased from an outside service, including reference laboratory testing, drugs, x-ray interpretation by a consulting radiologist, pathology testing and other such services. You must complete this form every 12 months or if your financial situation changes.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| |NAME |  |  |  |  |  |
| STREET | CITY | STATE | ZIP | Phone |  |

Please list all household members, including those under age 18.

|  |  |  |
| --- | --- | --- |
|  | Name | Date of Birth |
| SELF |  |  |
| OTHER |  |  |
| OTHER |  |  |
| OTHER |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Source | Self | Other | Total |
| Gross wages, salaries, tips, etc. |  |  |  |
| Other Income |  |  |  |
| Total Income |  |  |  |

**I certify that the family size and income information shown above is correct.**

**Name (Print):**

**Signature: Date:**

Date

**Office Use Only**

|  |  |  |
| --- | --- | --- |
| Verification Checklist | Yes | No |
| Identification/Address: Driver's license, utility bill, employment ID, or other |  |  |
| Income: Prior year tax return, three most recent pay stubs, or other |  |  |

Self-declaration of income may also be used.

 **Application approved for % discount for 12 months from today’s date:**

 **Application denied for the following reason:**