Modoc Medical Center
1111 North Nagle Street
Alturas, CA 96101
530-708-8800 x11053

Dear Patient,

If you are in need of financial support for one or more invoices with Modoc Medical Center (MMC), please complete the attached application in its entirety and sign the application where indicated. Please also provide the required documents, as described in the application. Upon receiving the application and the required documentation, we will determine if you qualify for the Reasonable Payment Plan, the Discount Payment Program, or the Financial Assistance Program.

Our Patient Financial Services Department is available to give personal assistance by appointment only. During this visit, they can evaluate and help you find the best resolution for your individual needs. In addition, they can help patients apply for Medi-Cal and provide information about other insurance plans through the California Health Benefit Exchange, commonly known as Covered California.

Our goal is to help you find a reasonable solution so you can pay your bills with MMC. Please note the following information:

- This application must be turned in to Patient Financial Services within 15 days from the date of your billing statement.
- If you need help completing this application, please contact Patient Financial Services at the number below or please see Patient Financial Services at the location below.
- All properly completed applications will be processed within a period of (1) working day following receipt. A final determination letter will be provided.
- Any incomplete application will be returned together with a letter outlining the information required to process the request. Complete applications will remain valid for 180 days.
- Any application submitted for the Financial Assistance Program that does not qualify will automatically be considered for the Discount Payment Program and Reasonable Payment Plan; you are not required to submit another application.
- If you currently hold insurance, you do not qualify for the Financial Assistance Program but you may contact Patient Financial Services below for a Reasonable Payment Plan.

**Return the completed application, together with all the supporting documents within 15days from the date of the application.The application can be submitted by mail, fax, or email at:**

**Modoc Medical Center**
**Attn: Patient Financial Services**
**PO Box 190**
**Alturas, CA 96101**
**Phone: 530-708-8800 ext. 11053**
**Fax: 530-233-7609**
**Attn:Patient Financial Services**
**E-mail:** bphilpot@modocmedicalcenter.org

Thank you for choosing Modoc Medical Center for your health care needs. We look forward to assisting you with your request.

Sincerely,

Modoc Medical Center

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# Application for Financial Assistance

## 1) Responsible Party Information

Last Name | First Name | Social Security Number (Optional) | Date of Birth

Physical Address | Post Office Box | City | State/Postal code

Home Phone Number | Alternate/Cell Phone Number

Name of Employer | Job Function/Title | Employer Phone #

Gross Annual Income | Employer Address: Street, City, State, Zip Code

Spouse's Name | Social Security Number (Optional) | Date of Birth

Name of Employer | Job Function/Title | Employer Phone #

Gross Annual Income | Employer Address: Street, City, State, Zip Code

## 2) Health Insurance Information

Current Health Insurance Company | Current Identification # | Current Group #

☐ Check this box if no insurance is currently held.

☐ **Check this box if a Medi-Cal application has been filed and denied. (Required)**

## 3) People in Household

| | Name | Relationship with the Patient | Date of Birth | Employer | Employer Telephone |
|---|---|---|---|---|---|
| 1. | | | | | |
| 2. | | | | | |
| 3. | | | | | |
| 4. | | | | | |
| 5. | | | | | |
| 6. | | | | | |
| 7. | | | | | |
| 8. | | | | | |

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## 4) Income & Asset Information

In order to determine the extent of your eligibility for the MMC Reasonable Payment Plan, Discount Payment Program or Charity Care Program, please complete the required section below. Please note that each program requires different information.

Monthly Income: Required for Reasonable Payment Plan, Discount Payment Program, and Charity Care Program

| | | |
|---|---|---|
| Job Income: | $ | **Required Documentation**<br>One or more of the following: |
| Spouse's/Domestic Partner Job Income: | $ | ☐ All paystubs from the last 90 days. |
| Business Income: | $ | ☐ Most current W-2 for all working adults. |
| Rental Income: | $ | ☐ Copy of most recent filed tax return. |
| Interest/Dividend Income: | $ | ☐ Social Security Statement. |
| Social Security Income: | $ | ☐ If no income, please attach a signed letter stating circumstances. |
| Alimony or Support Income: | $ | |
| Other Income:_____ | $ | |
| **Total Monthly Income:** | $ | |

**Current Monthly Essential Living Expenses· Required for Reasonable Payment Plan (Optional)**

| | | |
|---|---|---|
| Mortgage/Rent Payment: | $ | **Required Documentation**<br>One or more of the following: |
| Insurance Premiums (health, auto, home): | $ | ☐ Proof of amount of most recent mortgage/rent paid. |
| Utilities (gas, elect., water, phone): | $ | ☐ Most current statements for any expense listed/claimed on this application. |
| Automobile Payment(s): | $ | ☐ Receipts/proof of payment for amounts paid for food/medical expenses paid in the last full month. |
| Food: | $ | |
| Other:_____ | $ | |
| Other:_____ | $ | |
| **Total Monthly Essential Living Expenses:** | $ | |

| **Qualified Monetary Assets for Charity Care (Optional)** | | **Additional Documentation (Optional)** |
|---|---|---|
| Checking Account(s): | $_____ | One or more of the following: |
| Savings Account(s): | $_____ | ☐ Most recent bank statements. |
| Stocks, Bonds & CDs: | $_____ | ☐ Most recent Quarterly Statement for stock(s), bond(s), or CD(s). |
| Other:_____ | $_____ | ☐ Other: Most recent statement showing total monetary worth of the assets. |
| **Total Qualified Monetary Assets:** | $_____ | |

By signing below, you are asking to be considered for MMC's Discount Payment Program, Reasonable Payment Plan or Charity Care Program. In addition, 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 MMC to check your references and credit history in order to determine eligibility for the Discount Payment or Charity Care Programs.

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 MMC of such payment. Modoc Medical Center reserves the right to collect the original, full billed amount for rendered services should a third-party provides you with payment for those services.

_____ _____

Signature of Applicant (Responsible Party) Date