Patient Financial Services
1111 N. Nagle Street
Alturas, CA 96101
530-708-8819

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 the extent to which you qualify for sliding discounts based on your income.

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:

- If you need help completing this application, please contact Patient Financial Services at the number below to make an appointment.
- All properly filed 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 will automatically be considered for Sliding Discounts and Reasonable Payment Plans; you are not required to submit another application.

Return the completed application, together with all the supporting documents within **30 days from the date of the application. The application can be submitted by mail, fax or email at:**

Modoc Medical Center
Attn: Patient Financial Services
1111 N. Nagle Street
Alturas, CA 96101
Phone: 530-708-8819
Attn: Patient Financial Services

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

Sincerely,

Marina Ruiz
Patient Financial Services
(530) 708-8819

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Application for Financial Assistance

1) Responsible Party Information

Last Name	First Name	Middle Name	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 #	

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.

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, or Sliding Fee Discounts, please complete the required section below. Please note that each program requires different information.

Monthly Income: Required for Reasonable Payment Plan and Sliding Fee Discounts

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

Current Monthly Essential Living Expenses· Required for Reasonable Payment Plan

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

_____ _____
Signature of Applicant (Responsible Party) Date

By signing below, you are asking to be considered for MMC's Sliding Fee Discount Program or a Reasonable Payment Plan. 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.

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 provide you with payment for those services.