



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. A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable.

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.
- Patients that qualify for the charity care program will receive greater financial assistance than patients that only qualify for the discount payment program.

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

Signature of Applicant (Responsible Party)

Date

By signing above, 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 above, 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.