MEDICAL FINANCIAL ASSISTANCE PROGRAM

Please complete the enclosed application to help us determine your eligibility in our financial assistance program. Please return this application to the Patient Accounting Department along with the following documents:

- χ Income Verification:
  - χ Last 3 months payroll check stubs
  - χ Your latest Federal tax return
  - χ Verification of Unemployment compensation
  - χ Social Security Benefit Verification
  - χ Other _____
- χ Latest bank Statement(s)
- χ Copies of medical bills
- χ Utility Bills
- χ Other _____

This application MUST BE RETURNED TO the Patient Accounts Department or Financial Counselor WITHIN 14 DAYS. If additional time is required due to your medical condition, or if assistance with this application is needed, please contact a Financial Counselor at (775) 445-8609.

The hospital will notify you of determination of eligibility within 14 days of receipt of completed application.

All information relating to this application will be kept completely confidential

FINANCIAL APPLICATION

This application will cover all **active** accounts for:
Guarantor (Responsible Person): _____

Head of Household
Spouses Name
Street Address
City, State, Zip Code
Telephone Number

Individuals Residing in Household (List First AND Last Name)

NAME	Relationship	Age

LIST ALL INCOME FOR YOUR HOUSEHOLD

Source of Income	Monthly Income	Hourly Rate	AVERAGE hours worked per week
Pension/Retirement			
Social Security			
Wages Earned (Head of household)			
Wages Earned (Spouse)			
Unemployment Compensation			
Alimony			
Child Support			
Public Assistance			
Other Income			
TOTAL			

MONTHLY EXPENSES

Rent	$	Gasoline	$
Food	$	Insurance	$
Electric	$	Pharmacy	$
Heating Fuel	$	Child Care	$
Phone	$	Child Support	$
Cable TV	$	Alimony	$
Water	$	Other	$

ASSETS

Description	Year / Make	Value	Balance	Monthly Pmt	Institution
Home					
Automobile					
Automobile					
RV / Boat					
Cash on Hand					
Stocks/Bonds/M Fnd					
Life Insurance					

OTHER EXPENSES

List Name	Current Balance	Monthly Payment
Bank / Credit Union (Credit or Loans)		
	$	$
	$	$
TOTAL Medical Bills **(attach statements)**	$	$
Collection Agency Debt	$	$
Other	$	$

AUTHORIZATION

I request that Carson Tahoe Regional Healthcare utilize the attached information to determine my eligibility for a charity care adjustment. I understand that the information submitted is subject to verification and approval will be based upon that verification. I authorize Carson Tahoe Regional Healthcare to obtain information from any source deemed necessary to determine an acceptable financial agreement and/or assist me in obtaining financial assistance. In so authorizing, I release any person(s) or business(s) from any/all liability connected with said release.

_____ _____

Signature of Responsible Party Date