Application Due: _______________

Community Care Financial Assistance Application

Dear Patient,

You have requested financial assistance for one or more accounts with Orchard Hospital. Please complete the attached application and submit with the required documentation listed below for review to determine the extent to which you qualify for our Community Care programs.

Our Credit/Collections Specialist is available for personal assistance by appointment.

Please note the following information:

- If assistance if needed to complete this application, please contact our Credit/Collections Specialist to schedule an appointment.
- All properly submitted applications will be processed within 10 business days of receipt. A final letter of determination will be provided.
- Any incomplete applications will be returned upon receipt with a letter advising what information is needed in order to process the application.

Return your completed application along with <u>all supporting documentation</u> within 30 days of receipt of the application. Applications may be mailed or faxed to the following:

Orchard Hospital
Attn: Credit/Collections Specialist
240 Spruce Street
Gridley, CA 95948

Fax: 530-846-9075, attention: Credit/Collections Specialist

Thank you for choosing Orchard Hospital for your health care needs. We look forward to assisting you further.

Best Regards,

Yolanda Del Rio
Credit/Collections Specialist
530-846-9011

Community Care Financial Assistance Application

1) RESPONSIBLE PARTY INFORMATION

Last Name _______________ First Name _______________ Social Security # _______________ Date of Birth _______________

Home (Physical) Address _______________ Mailing Address _______________ City _______________ State/ Zip Code _______________

Home phone # _______________ Alternate/Cell Phone # _______________

Employer Name _______________ Job Function/Title _______________ Employer Phone # _______________

Gross Annual Income _______________ Employer's address: Street, City, State, and Zip _______________

Spouse's Name _______________ Social Security # _______________ Date of Birth _______________

Employer Name _______________ Job Function/Title _______________ Employer Phone # _______________

Gross Annual Income _______________ Employer's address: Street, City, State, Zip _______________

2) People In Household

	Name	Relationship to Patient	Date of Birth	Employer	Employer Telephone
1					
2					
3					
4					
5					
6					

3) Income & Asset Information

In order to determine the extent of your eligibility for the OH Community Care program, please complete the required sections below. Please note, different information is required for each program.

Monthly Income: Required for Community Care.

Job Income: $_____________

Spouse Job Income: $_____________

Business Income: $_____________
Rental Income: $_____________
Interest/Dividend Income $_____________

Social Security Income: $_____________

Alimony or Support Income: $_____________

Other Income: $_____________

Total Monthly Income $_____________

Required Documentation

One or more of the following:

- ☐ All paystubs from the last 90 days.
- ☐ Most current W-2 for all working adults.
- ☐ Copy of the most recent filed tax return.
- ☐ Social Security Statement
- ☐ If no income, please attach a signed letter stating circumstances.

Qualified Monetary Assets: Required for Community Care

Checking Account(s) $_____________

Savings Account (s) $_____________

Stock, Bonds & CDs $_____________

Other:___________________ $_____________

Total Qualified Monetary Assets $ _________________

Required Documentation

One or more of the following:

- ☐ Most recent bank statements.
- ☐ Most recent Quarterly Statement for stock(s), bond(s), or CD(s).
- ☐ Other: Most recent statement showing total monetary worth of asset.

By signing below you agree to be considered for OH Community Care Program. Additionally, 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 Orchard Hospital to check references and credit history in order to determine eligibility for Community Care consideration.

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 the hospital of any such payment. Orchard Hospital retains the right to collect the original, full billed amount for rendered services should a third party provide you with payment.

____ ____________________

Signature of Applicant **Date**