FAIRCHILD MEDICAL CENTER

FINANCIAL ASSISTANCE APPLICATION

For this application to be considered for financial assistance, please include the following information, or an explanation as to why this information is not available, with your completed application. Missing documentation may result in a delay in your application and could result in a denial of financial assistance.

Type of Income	Documentation
Employment Income	Copy of Individual tax return (1040) for current tax year Copy of two months most recent pay stubs
Self-Employment Income	Copy of Individual tax return (1040) for current tax year, along with all accompanying schedules
Social Security/Retirement	Copy of Individual tax return (1040) for current tax year Copy of Award Letter from Social Security stating monthly payment Copy of monthly payment notification from Social Security Administration
Disability	Copy of Individual tax return (1040) for current tax year Copy of Award Letter stating disability payments Copy of monthly notification from disability
Unemployment	Copy of Individual tax return (1040) for current tax year Copy of letter stating monthly award amount

Please return your completed application with all documentation in the enclosed self-addressed envelope within 14 days. If you have any questions, please contact one of our Financial Counselors at (530) 841-8537.

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Family Information: Please provide the names of all family members to be considered for financial assistance.

Last Name:	First Name:	Medical Record Number:
Last Name:	First Name:	Medical Record Number:
Last Name:	First Name:	Medical Record Number:
Last Name:	First Name:	Medical Record Number:
Last Name:	First Name:	Medical Record Number:

Applicant (Guarantor) Information: (Circle one)

Relationship to Patient

❒ Self ❒ Spouse/Domestic Partner ❒ Parent ❒ Other

Last Name: First Name:			
Date of Birth:	No. of Dependents:	Ages of Dependents:	Phone:
Street Address, city, state, zip code:			
Employer:	Employers address, city state, zip code:		
If not currently working, how long have you been unemployed:			

Co-Applicant (Guarantor) Information: (Circle one)

Relationship to Patient

❒ Self ❒ Spouse/Domestic Partner ❒ Parent ❒ Other

Last Name: First Name:			
Date of Birth:	No. of Dependents:	Ages of Dependents:	Phone:
Street Address, city, state, zip code:			
Employer:	Employers address, city state, zip code:		
If not currently working, how long have you been unemployed:			

Income Information:

Monthly Income Sources	Applicant	Co-Applicant	Combined Monthly Income
Employment Wages			
Self-Employment			
Unemployment			
Pensions/Retirement			
Workers Comp			
Social Security			
Disability			
Child Support			
Alimony			
Other Income			
Total Monthly Combined Income: $			
Total Number of People in Household:			
If you do not have monthly income, please explain how you take care of your monthly expenses. Use additional page if necessary.			

MONTHLY EXPENSES:

Mortgage/Rent:	Electricity:	Gas/Oil/Kerosene (heating):
Water/Sewer/Garbage:	Phone/Cable/Internet:	Medical/Dental Expenses:
Prescriptions:	Medical Insurance:	Vehicle Payment:
Vehicle Insurance:	Vehicle Gas:	Vehicle Maintenance:
Homeowners/Renters Insurance:	Child Support:	Childcare:
Laundry:	Other:	Other:

CERTIFICATION:

I certify that the information listed on this application is true and correct to the best of my knowledge. I understand that the information provided is to be used to determine my ability to pay for services at Fairchild Medical Center.
I understand that all the information provided is subject to verification. I hereby give permission for Fairchild Medical Center to receive, release, or act upon financial information contained herein. I also release Fairchild Medical Center and any party from liability from any acts, communications, or disclosures which are made pursuant to such an investigation. I understand that if the information which I submit is determined to be false, such a determination will result in a denial of this application, and I will be liable for all charges.

_____ _____
Signature (Patient/Applicant) Date

_____ _____
Signature (Co-Applicant) Date

For Office Use Only:

Process Date: _____ ❒Approved ❒Denied Expiration Date: _____

Processed by: _____ Approved % Rate _____