FAIRCHILD
MEDICAL CENTER

Financial Assistance Application

In order 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 for 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

Other Documentation that may be required:
Copy of state CMSP/Medi-Cal denial notice (if applicable). You may obtain this by contacting the Department of Social Services in the area in which you live. All potentially eligible patients must provide a valid "Notice of Action" from Department of Social Services stating that completions of the application and reason for acceptance or denial. *(NOTE: Any "Notice of Action" stating a failure to provide information or failure to participate in the interview will not be accepted in consideration of this application for financial assistance.)*

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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FINANCIAL ASSISTANCE APPLICATION

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

Marital Status: ❒ Single ❒ Married/Domestic Partner ❒ Widow/Divorced

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

Marital Status: ❒ Single ❒ Married/Domestic Partner ❒ Widow/Divorced

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:			

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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.			

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FINANCIAL/BANKING INFORMATION

Bank Name:	Account Type (Checking or Savings):	Account Balance:
Bank Name:	Account Type (Checking or Savings):	Account Balance:
Bank Name:	Account Type (Checking or Savings):	Account Balance:

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 _____