



500 East First Ave.  
Portola, CA, 96122  
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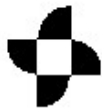
Dear Patient,

At Eastern Plumas Health Care we are committed to helping the needs of our community. Attached you will find the Charity Care Application, please fill out all pages completely. In addition, please provide the following accompanying information with your application:

- a) Copies of your prior three months bank statements.
- b) Copy of your last Federal Income Tax return filed.
- c) Copies of your prior three months' paycheck stubs.

For us to process your request we will need the enclosed form completed and returned to our business office within 30 business days from time of service. Upon receipt of the above information, you will be notified of our decision. Should you require further clarification or have any questions, please contact me at (530) 832-6568.

Sincerely,  
April Shepherd  
Patient Financial Service Coordinator  
Eastern Plumas Health Care



**Eastern Plumas Health Care**

*"People Helping People"*

**CHARITY CARE FINANCIAL STATEMENT**

Date of Request: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Telephone No.: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Address: \_\_\_\_\_

Account #: \_\_\_\_\_ Dates of Service: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Name of Spouse: \_\_\_\_\_

Employer: \_\_\_\_\_ Last Day Worked: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Last Day Worked: \_\_\_\_\_

Do you have? Medicaid \_\_\_\_\_ Medicare \_\_\_\_\_ Other Insurance \_\_\_\_\_

Gross Annual Family Income: Self: \$ \_\_\_\_\_

Spouse: \$ \_\_\_\_\_

Other: \$ \_\_\_\_\_

Total: \$ \_\_\_\_\_

Number of Dependents Supported on Income (Include Self): \_\_\_\_\_

Provider of Financial Information (If other than patient or guarantor):

Name: \_\_\_\_\_

Address: \_\_\_\_\_

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**DO NOT COMPLETE** (To be completed by Hospital Personnel only).

This document was received on: \_\_\_\_\_

By: \_\_\_\_\_ Title: \_\_\_\_\_



**CHARITY CARE FINANCIAL STATEMENT**

Patient Full Name		Birthdate	Social Security Number	
Physical Address				
Mailing Address (if different)			Telephone Number	
Patient Employer Name				
Employer Address			Employer Phone Number	
Patients Previous Employer (if within two Years)		Position	Years of Employment?	
Salary, Wages, or Commissions Earned				
Weekly:	Bi-Weekly:	Semi-Monthly:	Monthly:	
Other Income Per Month		Source of Other Income		
Spouse Full Name				
Spouse Full Name		Birthdate	Social Security Number	
Spouse Employer Name			Employer Phone Number	
Employer Address				
Numbers of Members in Family				
Name	Relationship	Age	Gender	

Bank Name		Branch	
Checking Account Number		Saving Account Number/ Loan Number(s)	
Do you Rent or Own a Home?		Monthly Payment	
Description of Real Estate Owned	Value	Amount Owed	
Make, Model and Year of Vehicle Owned		Amount Owed	
Make, Model and Year of Vehicle		Amount Owed	
List All Debts (attach additional sheets if necessary)			
Creditor	Address	Balance Owing	Monthly Payment
Creditor	Address	Balance Owing	Monthly Payment
Creditor	Address	Balance Owing	Monthly Payment

**I UNDERSTAND THAT THE INFORMATION WHICH I SUBMIT IS SUBJECT TO VERIFICATION BY EASTERN PLUMAS HEALTH CARE AND SUBJECT TO REVIEW BY GOVERNMENTAL AGENCIES. I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time \_\_\_\_\_

Printed Name: \_\_\_\_\_