Eastern Plumas Health Care
"People Helping People"

Financial Assistance Application - Instructions

If you need help paying your medical bill, you may be eligible for financial assistance from Eastern Plumas Health Care (EPHC). Any individual whose family income is at or below 400% of the Federal Poverty Level and is either uninsured or has high medical costs may be eligible for the hospital's charity (free) care or discounted care. To determine eligibility for financial assistance, please follow the instructions below to complete the Financial Assistance Application, including submission of supporting documentation, as applicable.

You may be eligible for government programs such as Medi-Cal and other government-funded healthcare assistance programs. Additionally, you are welcome to obtain applications for coverage offered through the California Health Benefit Exchange: www.coveredca.com or call our Financial Counseling Office at 530-832-6500.

1. **Completion**: Please complete all areas on the attached application form. If any area does not apply to you, please write N/A (not applicable) in the space provided.

2. **Charity (Free) or Discounted Care:** For purposes of determining eligibility, we request that you submit documentation of income limited to (i) paystubs within six months before or after the patient is first billed or (ii) income tax returns from the year the patient was first billed or 12 months prior to when the patient was first billed. EPHC may accept, but does not require that you submit, other forms of documentation of income.

3. **Submission**: If you have questions, please call your account representative at 530-832-6500.

Mail or deliver your completed application in person to:

Eastern Plumas Health Care

ATTN: Financial Counseling Office

500 First Ave Portola, CA, 96122

PATIENT FINANCIAL ASSISTANCE APPLICATION

Please check the type of financial assistance you are interested in applying for:

☐ Charity Care (Free)
☐ Discount (Reduced) Payment Program. Patients applying only for the Discount Payment Program may receive less financial assistance than what may be available to them under the Charity Care Program

ACCOUNT/MEDICAL RECORD #: _____

PATIENT INFORMATION	
RESPONSIBLE PARTY NAME: LAST FIRST M.I	
PATIENT NAME IF OTHER THAN RESPONSIBLE PARTY:	SOCIAL SECURITY #:
ADDRESS:	PHONE:
CITY, STATE & ZIP:	WORK/CELL PHONE:
EMPLOYER:	OCCUPATION:
SPOUSE INFORMATION	
NAME: LAST FIRST M.I	SOCIAL SECURITY #:
ADDRESS:	PHONE:
CITY, STATE & ZIP:	WORK/CELL PHONE:
EMPLOYER:	OCCUPATION:

LIST ALL FAMILY MEMBERS[1]		
NAME	RELATIONSHIP	AGE

MONTHLY INCOME (MUST BE BELOW 400% OF FPL FOR ELIGIBILITY)		
	PATIENT/ RESPONSIBLE PARTY	SPOUSE
GROSS WAGES (before deductions)		
OTHER INCOME		
INTEREST & DIVIDENDS		
REAL ESTATE RENTAL/LEASE		
SOCIAL SECURITY		
UNEMPLOYMENT/ DISABILITY		
ALIMONY/CHILD SUPPORT		

[1] Family is defined as:

i) For persons 18 years of age and older, spouse, domestic partner, dependent children under 21 years of age, or any age if disabled, whether living at home or not, and

ii) For persons under 18 years of age or for a dependent child 18 to 20 years of age, parent, caretaker relatives, and other children under 21 years of age, or any age if disabled, of the parent or caretaker relative.

PLEASE IDENTIFY BASIS FOR ELIGIBILITY **(MUST BE EITHER UNINSURED OR HAVE HIGH MEDICAL COSTS)**
Are you uninsured? YES: ☐ NO: ☐
Do you have high medical costs? High medical costs is defined in the Financial Assistance Policy; it generally means that you spent over 10% of your annual income over the last 12 months on medical expenses. YES: ☐ NO: ☐ If you believe that you have high medical costs from expenses incurred from providers **other than EPHC**, please provide supporting documentation of those medical expenses.

By signing below, I/We declare that all information provided is true and correct to the best of my/our knowledge.

I/We authorize Eastern Plumas Health Care to verify any information listed in this application.

Patient Signature_____

Date_____

Spouse Signature_____

Date_____

Parent/Guardian_____

Date_____