Carson Valley Medical Center
YOUR COMMUNITY HOSPITAL

Date: _____

Account number(s) _____
_____

Dear _____,

As you are aware, Carson Valley Medical Center provides quality healthcare services to our community and visitors. It is our desire to assist you in payment of your account(s) as soon as possible. Our Financial Hardship Assistance Program may enable you to satisfy your account(s), depending on the information provided regarding your financial status.

If you are interested in this program, please fill out the enclosed form **COMPLETELY**, including this Cover letter, and return with application the following.

1. How many people are living in your household? _____.
   - Are they all members of your family? ___Yes ___No
   - What are their names, ages and relationship _____
     _____
2. Copy of Medicaid denial or hospital contracted eligibility service outcome.
3. Financial Information:
   - Income tax form for you and your spouse.
   - 90 days of most recent pay stubs for you and your spouse.
   - 3 most recent bank statements (all pages) for checking, savings and credit union.
4. Last 3 months of mortgage/rent receipts.
5. Statement of need (see form attached).
6. Statements from any other asset accounts (retirement funds, investments, insurance policies, etc.)

IMPORTANT:
If your completed application is not returned by _____, and/or all the Requested information is not included, it may be denied for non-compliance.

If you have further questions concerning the Financial Hardship Assistance Program, please do not hesitate to contact our office.

We will advise you of the status of your application. If there is any remaining balance, we will be happy to assist you.

Sincerely,

Patient Financial Advocate
775-783-3080

APPLICATION FOR CARSON VALLEY MEDICAL CENTER FINANCIAL ASSISTANCE
CONFIDENTIAL FINANCIAL STATEMENT

To be considered for the Carson Valley Medical Center ***Financial Hardship Assistance Program*** all applicants must attach a copy of the most recent Federal income tax return and three most recent pay stubs, complete Section A, and sign and date application.

To be considered for the Carson Valley Medical Center Financial Hardship Assistance program all applicants must first apply for governmental program assistance (Carson Valley Medical Center has resources available within the hospital to assist with the governmental program application process). After governmental program assistance has been determined, applicant can apply for Full or Partial Financial Assistance. To be considered for Full or Partial Financial Assistance applicant **must attach a copy of the most recent Federal income tax return, three most resent pay stubs, last three months of bank statements, last three months of mortgage/rent receipts, statements from any other assets**, and complete Section A and Section B. Finally, applicant must sign and date application before submission.

To be considered for ***Special Circumstance*** Financial Assistance (applicant does not meet qualifications for discount) all applicants must attach a copy of the most recent Federal income tax return or three most recent pay stubs and complete the entire form including Section C, and sign and date application.

SECTION A: All applicants must complete this section CA or NV Resident: How Long? _____ Check box if homeless _____

Name: _____
First Middle Last Phone #

Mailing
Address: _____
Number & Street City State Zip Code

Physical
Address: _____
Number & Street City State Zip Code

Marital Status (check one): Single ____ Married____ Divorced/Legally Separated: ____ Widowed: ____
Social Security #: _____ Date of Birth: _____
Spouse Social Security #: _____ Spouse date of Birth: _____

Applicant Employer: _____ Applicant Employer Address: _____
Applicant Occupation: _____

Spouse Employer: _____ Spouse Employer Address: _____
Spouse Occupation: _____

Amount of child support and alimony paid over the past 12 months: _____

Name	DOB	Income Type	Last 3 Months Income	Last 12 Months Income
			Total:	

SECTION B: Full or partial Financial Assistance and Special Circumstance ***<u>Applicants must complete this section</u>***

Cash accounts (do not include retirement accounts):

Bank Name: _____ Type of acct: _____ Account #: _____ Current Bal: $ _____
Bank Name: _____ Type of acct: _____ Account #: _____ Current Bal: $ _____

Number of dependents including spouse (whether or not living at home): (list ages): _____

To my knowledge, the information provided above is true. I authorize a Credit Bureau Report to be secured by the Hospital or its agent to verify my financial standing.

X _____ _____
Patient or responsible party signature Date

STATEMENT OF NEED: Full or partial Financial Assistance and Special Circumstance <u>Applicants must complete this section</u>

Please state the reasons or circumstances that led you to apply for assistance. (Some examples: change in employment status, unusual medical circumstances, insurance coverage, other problems)

SECTION C: Special Circumstance Financial Assistance Applicants complete this section

Voluntary Information:
Additional information you wish to be considered for Special Circumstances:

For assistance with your **Application,** contact our Patient Financial Advocate at: (775) 783-3080

For Office Use Only:
Met with Social Worker _____
Approved: ____ Denied: ____ Estimated dollar value of benefit provided: $_____

Comments: _____

<u>Date</u> **the above comments including reason for denial were entered onto patient's account: _____**