Date:

Account(s):

Dear Patient:

Enloe Medical Center is committed to providing financial assistance to patients without health insurance and to insured patients with high medical costs, to pay for medically necessary care. However, we understand that healthcare services should not represent a catastrophic burden to insured patients and families with high medical costs.

You have indicated that it is a financial hardship for you to pay for the services you recently received at Enloe Medical Center. Financial assistance is limited and in order to determine who qualifies, it is our policy to evaluate your income in comparison with federal income guidelines. If you have health insurance, we apply additional criteria that determine if you are eligible for full or partial financial assistance due to high medical expenses. To complete our evaluation, we require that you submit the attached application and return it with the following items.

Required **documentation**:

1. Complete **both sides** of the Confidential Financial Statement (attached)
2. Include a copy of any denial letters/statements from the Medi-Cal, CMSP or Covered California program (if applicable)
3. Include a copy of your last bank statement, *any and all* checking and savings, all pages.
4. If you have money market accounts, stocks, bonds or income properties other than your primary residence, we will need to see a statement of each account.
   ***Please note:*** *Qualified retirement plans are not included when we calculate income.*
5. If employed, please include a copy of the last two pay stubs for each family member.
6. If employment is intermittent, please include a copy of last year's tax return instead of pay stubs.
7. If you are not currently employed, please include proof of unemployment insurance, state disability or Social Security.
8. If you are insured with high medical costs, please provide proof of patient liability for medical providers other than Enloe Medical Center (if applicable).
9. Please include a letter explaining your financial situation and why you are unable to pay your bill. Your personal letter helps us understand your situation and why financial assistance is needed.

**Note:** If you are unable to provide any requested information, please explain why in the letter of hardship. If you have any questions about what is required, please contact your customer service representative.

All documentation must be **received within two weeks** of the date of this letter or your application could expire. We will process complete applications within two weeks of receipt and will notify you of our decision.

Respectfully,

Patient Financial Services
billing.helpline@enloe.org.
530-332-6300

ENLOE MEDICAL CENTER

# CONFIDENTIAL FINANCIAL STATEMENT AND FINANCIAL ASSISTANCE APPLICATION

Patient Name: _____

Account Number(s): _____ Date of Service(s): _____

## Responsible Party*

Name: _____

Address:_____

_____

Phone:_____

SSN:_____

Employer Name:_____

Employer Address:_____

_____

Employer Phone:_____

## Spouse or Domestic Partner

Name:_____

Address:_____

_____

Phone:_____

SSN:_____

Employer Name:_____

Employer Address:_____

_____

Employer Phone:_____

**Marital Status (circle one):** Married Single Divorced Widowed Unmarried Partnered

## Family Information:

Please list all persons living with you plus any children 21 or under, whether or not they live with you.

| **Name:** | **Age:** | **Relationship to you:** |
|---|---|---|
| 1._____ | _____ | _____ |
| 2._____ | _____ | _____ |
| 3._____ | _____ | _____ |
| 4._____ | _____ | _____ |
| 5._____ | _____ | _____ |
| 6._____ | _____ | _____ |

**Please complete other side.**

## Monthly Household Income:

| | | | |
|---|---|---|---|
| Gross monthly income from wages: | $_____ | Rental Income: | $_____ |
| Public Assistance/Food Stamps: | $_____ | Grants: | $_____ |
| Social Security: | $_____ | Workers' Compensation | $_____ |
| Unemployment Compensation | $_____ | Child Support/Alimony: | $_____ |
| Other: _____ | | $_____ | |

**TOTAL INCOME: $ _____**

## Monetary Assets

| | | | |
|---|---|---|---|
| Savings or Money Market: | $_____ | Stock Value: | $_____ |
| Dividends: | $_____ | Interest Payments: | $_____ |
| Property other than primary residence | $_____ | | |
| Other: _____ | | $_____ | |

**TOTAL ASSETS: $ _____**

## Expenses

| | | | |
|---|---|---|---|
| Monthly Home/Rental Payment: | $_____ | Medical/Dental: | $_____ |
| Medical Insurance Premium: | $_____ | Transportation: | $_____ |
| Utilities/Home Phone: | $_____ | Child Care/Tuition: | $_____ |
| Food/Home/Personal Necessities: | $_____ | Child Support/Alimony: | $_____ |
| Other: _____ | | $_____ | |

**TOTAL EXPENSES: $ _____**

*By signing this form, I authorize Enloe Medical Center to verify any and all information including a credit report, income and monetary assets. I understand that I may be required to provide proof of the information requested. Additionally, I certify that all the statements made on this application are true and complete to the best of my knowledge. Should it be determined that the information I provided is incomplete or false, any discount on my bill may be reversed, and payment in full may be expected of me.*

*If I receive payment from an insurance company, worker's compensation or any third party, I agree to inform the hospital of such payment. I understand that the hospital retains its right to collect the original, full billed charges should a third party provide full or partial payment for the hospital's services.*

_____ _____

Signature of Patient or Legal Guardian Date

_____ _____

Signature of Spouse Or Domestic Partner Date

*This document is to be completed by the patient's legal guardians if the patient is a minor.