MENDOCINO COAST DISTRICT HOSPITAL

Dear Patient,

You have requested financial assistance for one or more accounts for services provided by Mendocino Coast District Hospital. Please complete the attached application and submit with the required documentation for consideration of one of our available Financial Assistance Programs.

Our Financial Counselor is available for personal assistance by appointment. During this time, they can screen and assist with finding the best resolution for your individual needs. Additionally, they are able to assist patients in applying for Medi-Cal or other local and state programs.

It is our privilege to assist you through this process to find the best solution for you.

Please note the following information:

- If you need assistance to complete this application, please contact our Financial Counselor to schedule an appointment.
- All properly submitted applications will be processed within 10 business days of receipt. A final letter of determination will be provided.
- Any incomplete applications will be returned upon receipt with a letter advising what information is needed in order to process the application.
- Any application submitted for Charity Care consideration that does not qualify will automatically be considered for our Discount Payment or Reasonable Payment programs, a separate application is not necessary.

Return your completed application along with all supporting documentation within 30 days of receipt of the application. Applications may be mailed, emailed, or faxed to the following:

Mendocino Coast District Hospital
Attn: Financial Counselor
700 River Drive
Fort Bragg, CA 95437

Email: financialcounseling@mcdh.net

Fax: 707-961-4901, Attention: Financial Counselor

Thank you for choosing Mendocino Coast District Hospital for your healthcare needs. We look forward to assisting you.

Warm Regards,

Patient Accounts Representative - Financial Counselor
(707) 961-4684
financialcounseling@mcdh.net

MENDOCINO COAST HEALTH CARE DISTRICT

Financial Assistance Application

1. RESPONSIBLE PARTY INFORMATION

Last Name	First Name	Social Security #	Date of Birth
Home (Physical Address)	Mailing Address	City	State / Zip Code
Home Phone#	Alternate/Cell Phone#		
Employer Name	Employer Address		Employer Phone
Job Function/Title	Gross Annual Income		
Spouse's Name		Social Security #	Date of Birth
Employer Name	Employer Address		Employer Phone
Job Function/Title	Gross Annual Income		

2. PEOPLE IN HOUSEHOLD (INCLUDE THOSE YOU CLAIM ON YOUR TAXES)

	Name	Relationship to applicant	Date of Birth	Employer	Employer Phone
1					
2					
3					
4					
5					
6					
7					

700 RIVER DRIVE ▪ FORT BRAGG, CALIFORNIA 95437
PHONE: 707-961-1234 ▪ FAX: 707-961-4793 ▪
www.mcdh.org

3. INCOME & ASSET INFORMATION

In order to determine the extent on your eligibility for one of MCDH's Financial Assistance Programs, please complete the required sections below. Please note, different information is required for each program.

Monthly Income: Required for Reasonable Payment Plan, Discount Payment Program, and Charity Care

Job Income:	$_____
Spouse Income:	$_____
Social Security/Disability:	$_____
Business Income:	$_____
Rental Income:	$_____
Interest/Dividend Income:	$_____
Alimony or Support:	$_____
Other Income:	$_____
Total Monthly Income:	$_____

Required Documentation
One or more of the following:

- ☐ All paystubs from the last 90 days.
- ☐ Most current W-2 for all working adults.
- ☐ Copy of the most recently filed tax return.
- ☐ Social Security Statement(s).
- ☐ If no income, please attach a signed letter explaining circumstances.

Current Monthly Essential Living Expenses: Required for Reasonable Payment Plan

Mortgage/Rent:	$_____
Utilities (gas, water, electric, phone):	$_____
Insurance Premiums (health, auto, home):	$_____
Automobile (payments, gas, and maintenance):	$_____
Food:	$_____
Medical Bills:	$_____
Other:	$_____
Other:	$_____
Total Monthly Essential Living Expenses:	$_____

Required Documentation
One or more of the following:

- ☐ Proof of mortgage/rent paid monthly.
- ☐ Most current statements for any expense listed/claimed on this application.
- ☐ Receipts/proof of payment for amounts paid for food and medical expenses paid in the past 12 months (an average will be determined for application/eligibility purposes).

Qualified Monetary Assets: Required for Charity Care

Checking Account(s):	$_____
Savings Account(s)	$_____
Stock, Bonds, & CD's	$_____
Other:	$_____
Total Qualified Assets:	$_____

Required Documentation
One or more of the following:

- ☐ Most recent bank statements.
- ☐ Most recent quarterly statement(s) for stock(s), bond(s), or CD(s).
- ☐ Denial from Medicaid/Medi-Cal for date of service.

By signing below you agree to be considered for Mendocino Coast District Hospital's Discount Payment Program, Reasonable Payment Program, and/or Charity Care Program. Additionally, you certify that all of the statements and information provided on this application are true and complete to the best of your knowledge. Should it be determined that the information you provided is incomplete or false, any discount applied may be reversed and payment in fill may be expected from you. By signing below, you authorize Mendocino Coast District Hospital to check references and credit history in order to determine eligibility.

You further agree by signing below, that if you receive payment from an insurance company, workers' compensation plan, or any other third party, to inform Mendocino Coast District Hospital of any such payment. Mendocino Coast District Hospital retains the right to collect the original, full billed amount for rendered services should a third party provide

_____ _____

Signature of Applicant **Date**