TAHOE FOREST HOSPITAL DISTRICT

Financial Assistance Application

We know that you have a choice and appreciate the opportunity you have given us to care for you or your loved one. We understand that medical bills can be overwhelming at times so in order to help with this, Tahoe Forest Health System offers a Financial Assistance program. This program can assist qualifying patients who may have difficulty meeting their financial obligations associated with the healthcare services received within the Health System.

Enclosed you will find a financial assistance application. Please take the time to complete the application, attach the requested documents, and return the completed application. Please understand that any requested information is necessary in order to determine eligibility for this program. The application and supporting information is your opportunity to express your need for financial assistance through the Health System.

Please allow up to 90 days for processing once we have received your completed application. Once your application has been processed, you will receive a letter in the mail with the outcome of your application stating if you are approved for full financial assistance, approved for partial financial assistance, or denied. Emergent and urgent services are given priority consideration over elective services. If you are applying for services of a non-emergent nature, please allow additional time for consideration. You may be asked to make payment arrangements until a determination can be made. The Health System offers flexible payment plan options through HELP financial. Please note that only accounts through Tahoe Forest Health System are potentially eligible for this program.

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If you have any questions about the application, documents requested, require assistance with the application, or would like to set up a payment plan, please contact one of our Financial Counselors at (530)-582-6458.

Thank you,

Your Financial Counseling Team

Attention: If you need help in your language, please call 530-582-6458 where patients may obtain more information or visit 10121 Pine Avenue Truckee, CA 96161. The office is open 8:00 a.m. to 4:30 p.m. Monday through Friday. Aids and services for people with disabilities, like documents in braille, large print, audio, and other accessible electronic formats are also available. These services are free.
Note: Authority cited: Section 127010, Health and Safety Code. Reference: Sections 127405, 127410 127425, and 127430, Health and Safety Code.

Hospital Bill Complaint Program: The Hospital Bill Complaint Program is a state program, which reviews hospital decisions about whether you qualify for help paying your hospital bill. If you believe you were wrongly denied financial assistance, you may file a complaint with the Hospital Bill Complaint Program. Go to HospitalBillComplaintProgram.hcai.ca.gov for more information and to file a complaint.

Help Paying Your Bill. There are free consumer advocacy organizations that will help you understand the billing and payment process. You may call the Health Consumer Alliance at 888-804-3536 or go to https://healthconsumer.org for more information.

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Instructions:

1. **Completely fill out the attached application**. If an area does not apply put N/A. If you need more space to answer any questions, attach an additional page. Family size is determined by the number of individuals listed on the tax return including spouse and/or dependents. The application must be signed and dated to be considered complete.

2. **Attach all required documents. Applications must include:**
    a. **Letter of hardship** explaining why you are requesting assistance and any special circumstances demonstrating the need. Please comment on your living situation, expenses, any unusual circumstances, etc. Include the nature of services you are seeking assistance with (i.e. emergency room visit, surgery, elective services, etc.). The more information you provide explaining your situation, the better the Health System can determine the need for financial assistance.
    b. **Proof of income documents (federal tax return or paystubs)**
        i. **Federal tax:**
            1. Federal income tax return (Form 1040). You must include all schedules (i.e. Schedule C for self-employment) and attachments as submitted to the Internal Revenue Service in order for your application to be considered complete. State taxes are not required.
            2. If married and filing separately, you must include both sets of taxes.
            3. Recent tax returns are tax returns which document a patient's income for the year in which the patient was first billed or 12 months prior to when the patient was first billed.
        ii. **Or Paystubs**
            1. Paystubs within a 6-month period before or after the patient is first billed by the hospital, or in the case of preservice, when the application is submitted.
        iii. **If you have no proof of income documentation, please provide an explanation of how you support yourself/family in the hardship letter.**

3. **Submit completed application** with all documents to the address below or drop it off at the main lobby desk of the hospital.

Return your completed application by:

Mail:
Tahoe Forest Hospital District
Financial Counseling
PO BOX 759
Truckee, CA 96160

-or-

In Person:
Tahoe Forest Hospital
Financial Counseling
10121 Pine Ave
Truckee, CA 96161

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For patients applying only for discount payment program eligibility, the hospital may only request recent paystubs or income tax returns for documentation of income. The hospital may accept other forms of documentation of income but shall not require such other forms. Patients that only apply for discount payment program eligibility may receive less financial assistance than what may be available to them under the charity care program.
Note: Authority cited: Sections 127010 and 127435, Health and Safety Code. Reference: Section 127405, Health and Safety Code.

The below QR code is a Notice of Availability. If you are unable to access this, please reach out to our Financial Counseling Department. 530-582-6458 FinancialCounselors@tfhd.com

Patient/Guarantor Name		Patient/Guarantor Social Security Number	
Spouse Name		Patient/Guarantor Date of Birth	
Mailing Address		Home/Cell Phone	
		Work Phone	

ACCOUNTS		
List all accounts you are requesting assistance on:		

DO YOU HAVE ANY RELATED MSC (MULTISPECIALTY CLINIC) ENCOUNTERS TO BE CONSIDERED? YES / NO

FAMILY STATUS		
List all dependents that you support		
Name	Age	Relationship
1		

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3		
4		
5		

EMPLOYMENT STATUS	
Patient/Guarantor Employer	Position
Contact Person	Telephone
Spouse Employer	Position
Contact Person	Telephone

INCOME		
	Patient/Guarantor	Spouse
1. Gross Wages & Salary/Year (before deductions)		
2. Self-Employment Income/Year		
Other Income:		
3. Interest & Dividends		
4. Real Estate Rentals & Leases		
5. Social Security		
6. Alimony		
7. Child Support		
8. Unemployment/Disability		

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9. Public Assistance		
10. All Other Sources (attach list)		
Total Income (add lines 1 - 10 above)		

UNUSUAL EXPENSES	
Please provide information on any unusual expenses such as medical bills, bankruptcy, court judgments or settlement payments (attach list as needed).	
Description	Amount

Signature Page

By signing below, I/we declare that all information provided is true and correct to the best of my/our knowledge. I/we authorize Tahoe Forest Hospital District to verify any information listed in this application. We expressly grant permission to contact my/our employer.

_____ _____
Signature of Patient/Guarantor Date

_____ _____
Signature of Spouse Date

HOSPITAL USE ONLY
Application reviewed by: _____ Date: _____
Approved: __ Yes __No
Reason for denial_____