Date:

Account(s) #:

Dear Patient:

You have indicated a financial hardship for the services you recently received at Enloe Medical Center. It is our policy to evaluate your ability to pay in comparison with the federal guidelines to determine if you are qualified to receive community service benefits from this facility.

Required Documentation:

1. Complete **both sides** of the **Confidential Financial Statement** (Attached)
2. Copy of your **last bank statement(s).**
3. Copy of last year's **Income Tax return** or copy of last **two paycheck stubs** for you and your spouse.
4. Letter of **Financial Hardship.**

Please return all of the completed information to:

Enloe Medical Center
1390 E. Lassen Ave
Chico, CA 95973
Attn: Patient Financial Services / Community Service

All documentation **must be received within two weeks** or your application could expire. If you do not have all the required information, please include the reason in your letter of financial hardship. The more information you can provide us with will help in determining your individual situation.

Following review of all documentation, you will receive notice from us with our determination on your ability to pay.

Please note: Any physician fees that are incurred as a part of your visit are not included in our community service program. The account numbers begin with X, those charges will be your responsibility to pay. If you are unable to pay balance in full, please call our billing helpline at 530-332-6300 to set up a payment plan.

Please feel free to contact our office 530-332-6300 between the hours of 8 AM and 5 PM, if you should have any questions.

Thank you,
Enloe Patient Financial Services

CONFIDENTIAL FINANCIAL STATEMENT
&
COMMUNITY SERVICE APPLICATION

Patient Name: ______________________________

Account Number(s): ______________________ Date of Service(s): _______________

Responsible Party*

Name: ______________________________

Address: ______________________________

____

Phone: ______________________________

SSN: ______________________________

Employer Name: ______________________

Employer Address: ____________________

____

Employer Phone: ______________________

Spouse (if applicable)**

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 that you claim as dependents on your Federal Income Tax Returns:

Name:	Age:	Relationship to you:
1.		
2.		
3.		
4.		
5.		
6.		

Please complete other side.

Monthly Household Income:

Gross monthly income from wages: $_________

Public Assistance/ Food Stamps: $___________

Social Security: $____________

Unemployment Compensation: $___________

Child Support / Alimony: $_____________

Rental Income: $_____________

Grants: $______________

Workers' Compensation: $__________

Other:_______________ $____________

TOTAL INCOME: $_______________

Monetary Assets

Savings or Money Market: $____________

Dividends: $___________

Property other than primary residence: $__________

Stock Value: $______________

Interest Payments: $__________

IRAs: $_____________

Other: _____________ $___________

TOTAL ASSETS: $__________________

By signing this form, I authorize Enloe Medical Center 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.

______________________________________ ____________________

Signature of Patient or Legal Guardian Date

_______________________________________ ___________________

Signature of Spouse Date

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

** "Spouse" includes a patient's or guardian's legally registered domestic partner.