

Shasta Regional Medical Center
Financial Assistance Application

INSTRUCTIONS

1. Please complete all areas on the attached application form. If any area does not apply to you, write N/A in the space provided.

2. Attach an additional page if you need more space to answer any question

3. You must provide proof of income when you submit this application. The following documents are accepted as proof of income:

If you filed a federal income tax return you must submit a copy of:

a. Federal income tax return (Form 1040) from the most recent year. You must include all schedules and attachments as submitted to the Internal Revenue Service;

If you did not file a federal income tax return, please provide the following:

a. Two (2) most recent paycheck stubs; and

b. A letter explaining why you do not file a federal income tax return.

If you have no income, please provide a letter explaining how you support yourself/family.

4. Your application cannot be processed until all required information is provided.

5. It is important that you complete and submit the financial assistance application along with all required attachments within fourteen (14) days.

6. You must sign and date the application. If the patient/guarantor and spouse provide information, both must sign the application.

7. If you have questions, please call your account representative.

8. Send your completed application to:

Shasta Regional Medical Center
Patient Financial Services Department
1100 Butte Street
Redding, CA 96001

Shasta Regional Medical Center Financial Assistance Application

PATIENT/ GUARANTOR NAME		SPOUSE NAME	
ADDRESS		PHONE	
		Home	
		Work	
SOCIAL SECURITY NUMBER			
Patient/ Guarantor		Spouse	

FAMILY STATUS		
List all dependents that you support		
Name	Age	Relationship

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		
3. Other Income:		
3. Interest & Dividends		
4. Real Estate Rentals & Leases		
5. Social Security		
6. Alimony		
7. Child Support		
8. Unemployment/Disability		
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

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

Signature of Patient/Guarantor

Signature of Spouse

Date

Date