Marshall Medical Center
Attention: Financial Counselors
PO BOX 872
Placerville CA 95667

MARSHALL MEDICAL CENTER

Statement of Financial Condition

Section 1, Instructions:

In order to process your application, please make sure that you have completed **ALL** sections of this application, including the signature page and provide any proof of income that pertains to you.

Acceptable proof of income is as follows:

- Three most recent paycheck stubs
- Most current Tax Return Form
- Most current Schedule C Tax Form (for self-employed patients)
- Current Social Security Summary
- Current Unemployment Summary
- Current Disability Summary

An incomplete application will be returned and will not be processed until **all** required documents are received. Normal billing procedures will continue during this time.

Section 2, Applicant(s):

Applicant		**Spouse / Significant Other**	
Name:	_____	Name:	_____
Address:	_____	Address:	_____
	_____		_____
DOB:	_____	DOB:	_____
SSN:	_____	SSN:	_____
Phone:	_____		

Section 3, Dependents:

****List ONLY those dependents that are claimed on your Federal Income Tax return. For dependents over the age of 18, please provide your most recent tax return showing proof of dependency. ****

Name	Date of Birth	Relationship	Social Security #
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Section 4, Family Income: If no income, see section 5.

Current Monthly Income	**Patient**	**Spouse**	**Joint**
Gross Pay	$	$	$
Income from Business (if self-employed)	$	$	$
Interests and Dividends	$	$	$
From Real Estate and Personal Property	$	$	$
Social Security/Retirement Income	$	$	$
From Alimony, support payments	$	$	$
Other Income	$	$	$
Total Monthly Income	**$**	**$**	**$**

Assets (if applicable)	**Patient**	**Spouse**	**Joint**
Stocks and Bonds	$	$	$
Money Market Accounts	$	$	$
Brokerage Accounts	$	$	$
Certificates of Deposit/Savings Accounts	$	$	$
Total Assets	**$**	**$**	**$**

Section 5, Additional Information/ Means of support

Please use this section to provide additional information that may be pertinent to your eligibility for a discount. If you do not receive any income please explain your means of support. Example: How are you paying for food, rent, or other bills?

Section 6, Insurance Information:

Do you currently have health insurance coverage?

If yes, name of Insurance/Health Plan:_____
Identification Number:_____
Subscriber/Policy Holder Name:_____

Dependent Insurance if it differs:

If yes, name of Insurance/Health Plan:_____
Identification Number:_____
Subscriber/Policy Holder Name:_____

If you do not have active insurance, per Marshall Medical Center's policy, we require you to apply for Medi-cal and provide us with a determination letter. You can apply at www.coveredca.com or by calling the local Medi-cal office at 530-642-7300. If Medi-cal denies you, please pursue coverage through Covered California.

Section 7, Financial Assistance Application Checklist/Signatures

In order to prevent your application from being returned due to missing information, please review the checklist below.
Check all that you have completed.
If you require assistance in completing this application, please call our Financial Counselors at 530-626-2618. Our representative is available to assist you Monday through Friday between the hours of 8:00AM and 4:00PM.

- ☐ Completed sections 1-7 on this application.
- ☐ Included acceptable proof of income, refer to section 1 if you have any questions.
- ☐ Included Medi-cal determination letter. (If applicable)
- ☐ Signature and date for applicant.
- ☐ Signature and date for spouse and significant other. (If applicable)
- ☐ Signature for dependent over the age of 18. (If applicable)
- ☐ Federal Tax Income form if you have dependents over the age of 18.

_____ _____
Signature of Applicant *Date*

_____ _____
Signature of Spouse/Significant Other *Date*

_____ _____
Signature of Dependent over the age of 18 *Date*

*If you are over the age of 18 and being claimed on this application, we require your signature stating that you give permission to include you and any outstanding balances with Marshall Medical Center for this discount as well as on the Financial Assistance determination letter that will be sent out once the application is complete. If you decline to sign you will not be eligible for this discount.