TAHOE FOREST HEALTH SYSTEM

Dear Patient/Guarantor,

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, initial the checklist, and return the completed application within 30 days upon receipt. Please understand that any requested information is necessary in order to determine eligibility for this program. If the application is not completed and returned within the 30 days given, the application may be denied. 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.

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

Financial Assistance

Help With Your Medical Bills

Tahoe Forest Hospital District provides financial assistance to patients who are uninsured or underinsured. If you need help meeting your financial obligation, please contact a hospital representative at the numbers listed below. One of our representatives will gladly provide information and assistance without cost to you.

What if I do not have health insurance or if my health insurance does not cover my bills?

If you do not have health insurance plan coverage or your insurance did not pay your bill in full, financial assistance may be available through various government programs.

Tahoe Forest has representatives that can assist with the application process for these programs, including Medi-Cal, Medicaid, and state disability. These programs can assist with paying hospital, doctor, pharmacy and other medical bills. Please call **Eligibility Help at (530) 582-3279** for assistance.

For California Residents: You may be eligible for health coverage through Covered California or Medi-Cal Presumptive Eligibility. For information, visit the Covered California website at: www.coveredca.com. There are also organizations that will help patients understand the billing and payment processes. Please visit https://healthconsumer.org/ for more information.

For Nevada Residents: You may be eligible for health coverage through Nevada Health Link. For information visit the Nevada Health Link website at: https://www.nevadahealthlink.com/.

Financial Assistance- Plain Language Summary

If financial help through a government program does not meet your needs, you may be eligible for the Tahoe Forest Hospital District Financial Assistance Program. Eligibility is based on your family size and income. Depending upon your level of qualification, this program may allow for 100% or partially discounted responsibility of your Tahoe Forest Hospital District bill. You will need to complete an application and provide financial information in order to qualify. Please contact **Financial Counseling at (530) 582-6458** to begin the screening process.

2022 Federal Poverty Income Guidelines – Additional data will be provided for discounted service through our Financial Counselors

Family Size Income Guideline 1 $13,590 2 $18,310 3 $23,030 4 $27,750 5 $32,470 6 $37,190 7 $41,910 8 $46,630

Please note that the Financial Assistance Program applies to Tahoe Forest Hospital District bills only and you will need to make arrangements with other billing providers if applicable.

Tahoe Forest Hospital District provides financial assistance to patients who are uninsured or underinsured. If you need help meeting your financial obligation, please contact a hospital representative

at the numbers listed below. One of our representatives will gladly provide information and assistance without cost to you or your representative

We're available Monday- Friday, 8:00 am- 4:30 pm

Call us at: (530) 582-6458

Apply for Financial Assistance

Financial Assistance Applications

*Link to application in English

*Link to application in Spanish

Apply for Financial Assistance through MyChart

Login to your MyChart account to apply for Financial Assistance

https://mychart.tfhd.com/app/login?redirectType=mode&redirectUrl=financialassistance

Financial Assistance Policies and Resources

*Link to Financial Assistance Full Charity Care and Discount Partial Charity Care Policy English

*Link to Financial Assistance Full Charity Care and Discount Partial Charity Care Policy Spanish

*Link to Credit and Collection Policy English

*Link to Credit and Collection Policy Spanish

TAHOE FOREST HOSPITAL DISTRICT

Financial Assistance Application

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. **Copy of denial letter from Medi-Cal** if you applied and were denied within the last year.
   c. **Proof of income documents:**
      i. **If you filed a federal tax return you must submit a copy of:**
         1. Federal income tax return (Form 1040) and W-2's from the most recent year. 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.
      ii. **If you did not file a federal tax return must submit:**
         1. Two (2) most recent months of paycheck stubs and W-2's from the most recent year.
         2. A letter explaining why you did not file a federal income tax return.
         3. Three (3) most recent bank statements.
      iii. **If you have no proof of income documentation, please provide an explanation of how you support yourself/family in the hardship letter.**
      iv. **Any other proof of income documentation such as IRA contributions, Social Security funds, etc**.

3. **Initial the checklist** to ensure all requested documents are attached. If the item does not apply to you put N/A.

4. **Submit completed application** with all documents to the address below or drop it off at the main lobby desk of the hospital within 30 days of receipt.

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

TAHOE FOREST HOSPITAL DISTRICT

Financial Assistance Application

Checklist

Please initial on the line that each item is completed and included in your application or put N/A.

For all applicants:

- _____ **Signed and completed application form**
- _____ **Letter of hardship**
- _____ **Copy of denial letter from Medi-Cal**
- _____ **Additional proof of income (please list):_____**

_____

If you filed a federal tax return:

- _____ **Complete Federal Tax Return (Form 1040) from most recent year**
- _____ **W-2's from most recent year**
- _____ **Schedule C, if self-employed**
- _____ **Additional schedules (please list): _____**
- _____ **Spouse's tax return, if married and filing separately**

If you did not file a federal tax return:

- _____ **2 most recent months of paycheck stubs**
- _____ **Letter explaining why you did not file federal taxes**
- _____ **3 most recent bank statements**

TAHOE FOREST HOSPITAL DISTRICT

Financial Assistance Application

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		
2		
3		
4		
5		

EMPLOYMENT STATUS	
Patient/Guarantor Employer	Position
Contact Person	Telephone

TAHOE FOREST HOSPITAL DISTRICT

Financial Assistance Application

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		
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

TAHOE FOREST HOSPITAL DISTRICT

Financial Assistance Application

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_____