ATTACHMENT "C"

APPLICATION FOR COMMUNITY CARE PROGRAM

It is the policy of Carson Valley Health to provide essential services regardless of the patient's ability to pay. Discounts are offered depending upon household income and size. Please complete the following information and return it to the Financial Counselor to determine if you or members of your family are eligible for a discount.

The discount will apply to all services billed by Carson Valley Health. Please inquire with the Financial Counselor if you have questions.

Number of persons living in your household: ________________

Total household income: (complete one column)			
Household Member	Annual	Monthly	Bi-Weekly
Self			
Spouse			
Relatives			
Others			
TOTAL			

NOTE: Include ***gross*** income from all persons in household and income from all sources, including gross wages, tips, social security, disability, pensions, annuities, Veteran's payments, net business or self-employment, alimony, child support, military, unemployment, public aid, and other.

I certify that the household size and income information shown above is correct. Copies of tax returns, pay stubs, and other information verifying income may be required before a discount is approved.

Name (Print) Signature Date

_______________________ _____________________ _______________

Due Date:______________________________________

Please return to: Patient Financial Counselor
1107 US Hwy 395
Gardnerville, Nevada 89410
Phone 775-783-3080
Fax (775) 782-1504