Marin Healthcare District
Medical Care Centers

FINANCIAL ASSISTANCE PROGRAM

P: 1-415-493-3318

Name: _____ Date: _____

Account Number(s): _____

Dear Patient,

In order to process your application for financial assistance, please include the following information with your completed application:

- Copies of your 2 most recent pay stubs
  - *If unemployed:* Copy of monthly unemployment check
  - *If disabled/retired:* Copy of monthly social security/disability check
- 2015 Federal Tax Return (if self-employed, please include all schedules)
- Copies of bank statements for the most recent 2 months
- If you claim no income, you must provide documentation for how you support yourself

In the event that a Financial Assistance Application is received, but only partially completed, we will send you a request for the necessary documentation. Please note that until **all** requested information has been supplied, we will not submit your application for review, and you will continue to be billed for the total amount due.

Please return this information (be sure to include Attn: Financial Assistance Department) **within 25 days** from the date above to:

Mail: Marin Healthcare District
c/o MMPC Inc.
100 Wood Hollow Drive, Suite 160
Novato, CA 94945

Fax: 1-415-493-3301
Attn: Marin Healthcare District
Billing Department

We appreciate your timely response.

Sincerely,

Marin Healthcare District Billing Team

Helpful Hints

- If unable to provide something which has been requested, please send a letter explaining why.
- Your bank statement must show all deposits/withdrawals. If your deposits do not match your stated income, please explain why.
- If you are self-employed, please send in both personal/business bank statements.
- Please be sure to submit all information requested for both you, and your spouse.