Financial Assistance Application Form

Application Date

MM-DD-YYYY

Date

Date of Service

MM-DD-YYYY

Date

Patient Name

First Name

Last Name

Account Number

Address

Street Address

Street Address Line 2

City

State / Province

Postal / Zip Code

Phone Number

(000) 000-0000

Please enter a valid phone number.

Date of Birth

MM-DD-YYYY

Date

1) Was the patient a resident of California at the time of service?

- Yes
- No

2) Did the patient have medical insurance at the time of service?

- Yes
- No

3) Was the patient an active Medicaid recipient at the time of service?

- Yes
- No

If you answered yes to questions 2) or 3), please upload a copy of your insurance or Medicaid card to this application.

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Income

• All adult family members' income must be disclosed in the form of federal tax returns or recent pay stubs. • "Family" is defined as follows: (i) for persons 18 years of age and older, family means spouse, domestic partner, and dependent children under 21 years of age, or any age if disabled, whether living at home or not; and (ii) for persons under 18 years of age, or for a dependent child 18 to 20 years of age, family means parents, caretaker relatives, and other children under 21 years of age, or any age if disabled, of parent or caretaker relative. If the patient is a minor, the "family" is defined as the patient, the patient's natural or adoptive parents, and the parent's other children (natural or adoptive) who live in the patient's home.

	Family Member's Name	Age	Date of Birth	Relationship to Patient	Source of Income or Employer Name	Income For 3 Months prior to date of service	Income For 12 Months prior to date of service
1							
2							
3							
4							

Please upload additional family member information if applicable.

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Proof of income must be uploaded at the time of application (e.g., three months of pay stubs, or most recent tax return (IRS form 1040), etc.).

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My signature below certifies that everything I have stated on this application is correct and subject to review under audit. I understand, but if the information I provide is determined to be false, financial assistance may be denied, and I may be responsible for paying for the services provided. I understand that this application applies to both discount payments and charity care and that patients that only apply for discount payment may receive less financial assistance than what may be available to them under the charity care program.

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For any questions regarding this form, please contact Central Business Office's Patient Financial Services at 800-270-0702.

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