FINANCIAL ASSISTANCE APPLICATION INSTRUCTIONS

PLEASE NOTE, THIS FORM DOES NOT APPLY TO THE STATE OF CALIFORNIA MEDI-CAL PROGRAM

CHOC Children's requires the attached application and the supporting documents listed below to properly evaluate your request for a possible reduction of hospital expenses incurred at CHOC Children's in Orange or CHOC Children's at Mission Hospital.

Please complete all sections of the application. The documents listed as required must be included with your application. Any application that is missing information or that is submitted without the required supporting documents will be returned to you.

ATTENTION: THE FOLLOWING DOCUMENTS ARE REQUIRED.

These forms must be submitted along with your Financial Assistance application

The two (2) most recent paycheck stubs

Bank Statements from the past two (2) months

Federal Income Tax returns from the previous year

Please provide documentation that supports the following sources of Other Income, Assets or Other Resources including:

Social Security	Unemployment Benefits
Workers Compensation	Tax Refund
Welfare/AFDC	Stocks
Alimony	Bonds
Child Support	Trust Funds
Rents	Property (other than primary residence)

Support from family members or someone not living in the household

Please email your complete application and attach the required documents to FinancialAssistance@choc.org. Completed application can also be mailed to:

CHOC Children's
CHOC Family Payment Center
1201 W. La Veta Ave
Orange, California 92868-3874

If you need to contact the hospital regarding your application, please call contact the CHOC Family Payment Center at 714-509-8600.

The current published federal poverty guidelines are used in determining eligibility.
CHOC Children's Financial Assistance policy is available upon request.

Pt. Label

Personal Information
A

Patient Name:		
Sex: ☐ Male ☐ Female		**Patients SS#**
Patient's Date of Birth:		**Account Number**
Guarantor Name:		
Address:		
Does the patient have medical insurance?	**Yes**	**No**
Has patient applied for Medi-Cal or CCS?	**Yes**	**No**
Total Number of Family Members: (Include all children 21 and under)		**Family Members Ages:**
Is Patient a California Resident?	**Yes**	**No**
Is this for an Emergency Room Visit?	**Yes**	**No**

I certify that the information provided is true and accurate to the best of my knowledge. Further, I have or will apply for any assistance (Medi-Cal, Healthy Families, insurance, etc.) which may be available for payment of medical services, and that I will take any action reasonably necessary to obtain such assistance and will assign or pay to the hospital the amount recovered for medical services.

I understand that this application is a tool for the hospital to evaluate eligibility for financial assistance services. I also understand that the hospital will verify the information which may include obtaining a credit report. If the information I have given proves to be untrue, or if I fail to comply with the referral process for Medi-Cal, Medicare, California Children's Services, or other identified programs this may result in forfeiture of the right to be considered for the Financial Assistance Program.

Today's Date:_____ Date(s) of Service:_____

Signature: _____

Name: _____

Address: _____

_____

Contact Number: _____

Contact Email: _____

Assets/Income/Resources
B

Parent / Guarantor Information	Employer Information	Monthly Income (PRIOR to Taxes)
Parent #1 Name	Employer Name:	
		$
Parent #2 Name:	Employer Name:	
		$
Other Income (i.e. child support, alimony, unemployment, worker's comp)	Income Source:	
		$
		$

Annualized Income: $

Assets and Resources		
Funds	**Description**	**Value**
Checking:	Account Number:	$
Checking:	Account Number:	$
Checking:	Account Number:	$
Savings:	Account Number:	$
Savings:	Account Number:	$
Funds	**Description**	**Value**
Money Market	Type:	$
Stocks:	Type:	$
Bonds:	Type:	$

Personal Property	Description	Value	Equity
Property (Other Than Primary Residence)	Type	$	$
	Type:	$	$
	Type:	$	$
Assets and Resources:	Type:	$	$