Charity Care/Financial Assistance Application Form –

Confidential (Private)

Please fill out all information completely. If it does not apply, write "NA".

SCREENING INFORMATION
Has the patient applied for Medicaid/Medi-Cal? ☐ Yes ☐ No
Does the patient get state public services such as TANF, CalFresh, or WIC? ☐ Yes ☐ No
Is the patient currently homeless? ☐ Yes ☐ No
Is the patient's medical care need related to a vehicle accident? ☐ Yes ☐ No

PLEASE NOTE
• **We cannot guarantee that you will be able to get financial assistance, even if you apply.** • **Once you send in your application, we may ask for more information or proof of income.** • **Within 30 calendar days after we get your completed form and documents, we will let you know by letter if you can get assistance and the level of assistance.**

PATIENT AND APPLICANT INFORMATION		
Patient First Name	Patient Middle Name	Patient Last Name

Patient Sex Female ▫ Male ▫ Other (optional) ▫	Date of Birth	Patient Social Security Number (optional)
Date of Service	Account Number(s)	

Person Who Needs to Pay the Bill	Relationship to Patient	Date of Birth	Main Contact number(s)
Home or Mailing Address	Preferred Contact Method: Phone ▫ Email ▫ Mail ▫	Email Address	

Employment Status of Person Who Needs to Pay the Bill

▫ Employed (date of hire):_____ ▫ Unemployed (for how long?):_____ ▫ Self-Employed ▫ Student ▫ Disabled ▫ Retired ▫

Other (if other, please explain):

_____

FAMILY INFORMATION

List family members in your household, including yourself. "Family" is anyone who lives together that is related by birth, marriage, or adoption.

Total Family Size_____

Name of Each Family Member Living in Household	Age	Dependent of Person who needs to pay the bills (circle correct answer)	Total Income if older than 18 years old
		Yes No	
		Yes No	
		Yes No	
		Yes No	
		Yes No	

		Yes No	

TOTAL INCOME FOR ADULTS IN HOUSEHOLD		
Total dependents for person(s) who needs to pay the bills	Total Income for adult family members	**You must disclose all adult family members' income. Sources of income include but are not limited to wages, unemployment, self-employment, and child support.**
	$	
TOTAL INCOME FOR ADULTS IN HOUSEHOLD		

REMEMBER: You have to give us proof of income with your application.

We need proof of income to determine financial assistance.

All family members 18 years or older must let us know what their income is. If you cannot provide proof, you may write and sign a statement about your income and send it to us.

Examples of proof of income include but are not limited to:

- A "W-2" withholding statement
- Current pay stubs (minimum of 3 months)
- Last year's income tax return, including schedules if applicable
- Written, signed statements from employers or others

- Approval/denial letter of eligibility for Medicaid and/or state funded medical assitance
- Approval/denial letter of eligibility for unemployment payments

If you have no proof of income or no income, please attach a page explaining why.

EXPENSE INFORMATION

We use this information to get a full idea of your financial situation.

Monthly Household Expenses:

Rent/Mortgage: $ Medical Expenses: $

Insurance Premiums: $ Utilities: $

Other Debt/Expenses: $ (child support, loans, medicine, other)

OTHER INFORMATION

Please attach another page if there is more information about your current financial situation that you would like us to know. This can be financial hardship, too many medical expenses, seasonal or temporary income, or personal loss.

PATIENT AGREEMENT

I confirm that the above information is true and correct to the best of my knowledge. I understand that if the financial information I give is false, I may not get financial assistance. I may also need to pay for any services I get.

_____ _____

Signature of Person Applying Date

For Questions, please call (626) 408-9800

Return Completed Form by Mail To:

Monrovia Memorial Hospital

323 South Heliotrope

Monrovia, California 91016

OR

Return Completed Application by Email To:

amandam@mmhosp.com