Financial Assistance Application

Patient/Guarantor Name: _____

Hospital Account(s) # : _____

Our Financial Assistance Program helps low-income, uninsured or under-insured patients who needs assistance in paying for their medically necessary care. To be considered for Financial Assistance, please complete the application and provide the necessary documents to help determine whether you may qualify to receive a discount or a lesser monthly payment plan. We cannot guarantee that you will qualify, even if you apply. A written response will be provided to all patients supporting approval/denial after we receive your completed application and supporting documentation.

The policy covers medically necessary care provided at any of the Emanate Health Hospitals:

Queen of the Valley Hospital • Inter-Community Hospital • Foothill Presbyterian Hospital.

**Any other providers of services outside of the areas mentioned above may not be covered under this program. **

Financial Assistance Application Instructions

Please provide the following supporting documents listed below along with the complete application.

- Tax Return (1040) / W-2 or Paystubs (6 months)

If you will be applying for an Extended Payment Plan, please include the following documents:

- Copy of the following Statements (2 months): Mortgage/Rent, Utility Bills (Gas, Electricity, Water, Trash, Internet, Cellphone), Grocery Receipts (Food & House Supplies), Pay Stubs, Medical & Dental Expenses, Auto Expenses (Auto Finance Invoice, Car Repair Receipts, Car Insurance Invoice, Gas)

Please submit your completed application and supporting documents to:

Emanate Health Business Services
1325 N. Grand Ave. Ste. 300
Covina, CA 91724

Business Hours: 8:00 a.m. – 4:00 p.m.
Business Days: Monday – Friday, excl. Holidays
Phone Number: 626-732-3100

Please check the type of financial assistance you are interested in applying for:

☐ Charity Care or Discount Program ☐ Extended Payment Plan

Patient Information			
Patient Name	**Social Security Number**	**Date of Birth**	
Home Address	**City**	**State**	**Zip Code**
Home Number / **Cell Number**	**Email Address**		

Preferred Method of Contact ☐ US MAIL ☐ E-Mail ☐ Home Phone ☐ Cell Phone	**Annual Household Income:** $_____
Marital Status ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed ☐ Domestic Partner	**Number of Individuals reported on your taxes:**

Employment Status
☐ Employed ☐ Self-Employed ☐ Retired ☐ Disabled
☐Unemployed- Last date worked**:** _____

Employer Name	**Employer Phone Number**		
Employer Address	**City**	**State**	**Zip Code**

Spouse/Domestic Partner/Parent/Guarantor Information
*Please complete if the application is being completed by someone other than the patient.

Relationship to Patient
☐ Spouse ☐ Domestic Partner ☐ Parent ☐ Guarantor ☐ Other: _____

Name	Social Security Number	Date of Birth

Employment Status

☐ Employed ☐ Self-Employed ☐ Retired ☐ Disabled ☐Unemployed- Last date worked: _____

Employer Name	**Employer Phone Number**		
Employer Address	**City**	**State**	**Zip Code**

Insurance Coverage (Health Insurance or Third Party Insurance)

Are you eligible for any health insurance coverage? ☐ Yes ☐ No
If yes, please provide the following:

Health Insurance	**Policy Number**	**Subscriber Name**	**Subscriber DOB**
Third Party Insurance	**Adjuster Name**	**Adjuster Ph #**	**Claim #**

Supporting Documents

Charity Care or Discount Program *Please complete the form below and provide supporting documents.				
Documents to Provide		Patient/Guar	Spouse/Partner	Total
1	**Federal Tax Return** (1040)	Total Income $	Total Income $	$
2	**W-2 OR 1099 Form*** -If you did not file for Taxes	Amount shown in Box 1 $	Amount shown in Box 1 $	$
3	**Paycheck Stubs** (Past 6 Months)	Total Gross Income $	Total Gross Income $	$
			Total	$

Extended Payment Plan *Please complete the form below and provide supporting documents.				
Essential Living Expenses		Month 1	Month 2	**Total**
4	**Mortgage/Rent** (Past 2 Months)	$	$	$
5	**Utility Bills** (Past 2 Months)	$	$	$
6	**Grocery** (Past 2 Months)	$	$	$
7	**Medical and/or Dental Expenses**	$	$	$
8	**Auto Expenses**	$	$	$
			Total	$

Acknowledgement of Information

I, _____, am formally applying for financial assistance under the Emanate Health Financial Assistance Policy, as outlined by Federal Law. I am aware that the information I provide in this application is necessary to determine by eligibility for assistance and understand that additional information may be requested by Emanate Health.

I acknowledge that failing to submit any requested documentation within 30 days could lead to a denial of my application. Based on my income, I may qualify for uncompensated care or a partial discount. If granted a partial discount, I commit to paying any portion deemed due within 30 days or will reach out to Emanate Health Business Services to arrange a payment plan, if necessary. I understand that failure to pay the discounted balance could result in collection efforts by an outside agency.

I acknowledge that my Financial Assistance Application will expire 6 months from the date the application was received by Emanate Health Business Services.

By signing this application, I declare under penalty of perjury that all information submitted is true and correct and consent to allow Emanate Health Hospital's designated representative to verify the accuracy of the information provided.

Signature: _____ Date: _____

Print Name: _____

Hospital Acct # (s): _____

For Office Use Only

Received By: _____

Date Received: _____ Expiration Date: _____