Patient/Guarantor Name: _____

Account Number (s): _____

Financial Assistance Application

Emanate Health is committed to making health care available to everyone in our community, regardless of their ability to pay. Our financial assistance program helps low-income, uninsured or under-insured patients who need help paying for all or part of their medically necessary care. To be considered for financial assistance, please completed this application to help determine whether you may qualify to receive a discount. 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 facilities: Queen of the Valley Hospital, Inter-Community Hospital and Foothill Presbyterian Hospital.

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

Required Documents **From Patient/Spouse/Domestic Partner/Parent/Guarantor* ****Copies Only, No Originals****	Required
Completed & Signed Financial Assistance Application	Yes
Federal Tax Return (prior year) • To obtain proof of non-filing, call (800)908-9946 or Visit www.irs.gov/individuals/gettranscript (use form 4506-T or 4506T-EZ)	Yes
Paycheck Stubs (prior 2 months)	Yes
Unemployment, Social Security or Disability Award Letters (if applicable)	Yes
Bank Statements: Checking Account and Savings Account (if applicable)	Yes

Additional documents may be required.

Failure to submit the requested documentation within 30 days may result in a denial of financial assistance. Anyone found falsifying information will automatically be disqualified for financial assistance.

Financial Assistance Application

SECTION 1: Patient Demographics

Patient's Name: _____ SS # _____ DOB: _____

Current Address: _____ City: _____ State: _____

If the patient is a minor or if someone else claims you as a dependent; please provide the responsible parties information below.

Guarantor's Name: _____ SS # _____ DOB: _____

Current Address: _____ City: _____ State: _____

Have you previously applied for Medi-Cal or other government assistance? ☐ Yes ☐ No

Please explain: _____

_____

Were these services related to an accident or third party injury? ☐ Yes ☐ No

If yes, describe how your injury/accident occurred and who is responsible for covering the losses resulting from your incident?

_____

_____

_____

SECTION 2: Family Size

List all persons living in your household, their date of birth, social security # and relationship.

Name	Date of Birth	Social Security #	Relationship

Financial Assistance Application

SECTION 3: Property, Savings and Assets

Value of Home – if owned	$
Debt on Home – if owned	$
Checking Account Balance	$
Saving Account Balance	$
Assets of Business or Partnership	$
Other Assets	$

Total Assets	$

SECTION 4: Description of Financial Hardship

Please describe your income status, including your date of hire/last date of employment/retirement. If you do not have income, please describe how you meet your needs for food and shelter. If another person is providing support, please describe the type of support you are receiving, the estimated date you began receiving that support and the expected end date. Please ask the person to provide Emanate Health a letter describing the type of support, frequency and duration of the support.

Source of Income & Required Documents

On the following page (page 4), please identify ALL source of monthly income in your household. If someone else claims you as a dependent or is supporting you financially, their financial information is required. Place a ✓ next to the source of income that applies to you and/or the persons in your household. Write the name of the person receiving the income and the total amount received per month. In addition to completing this application, please SUBMIT all supporting income documentation for the persons you have listed along with YOUR supporting

income documentation, most recent filed tax return (1040), 2 months of savings/checking bank statements, and brokerage/investments statements (401/IRA).

Financial Assistance Application

Source of Income	✓	Documents Needed	Person Receiving Income	$ per Month
Wages		2 Current Paystubs		$
Hourly Rate				$
Average Monthly Hours Worked				$
Self-Employment Gross Receipts		YTD Profit & Loss Schedule 1		$
Partnership Income		YTD Profit & Loss Schedule 1		$
Social Security		Award Letter		$
Supplemental Security Income (SSI)		Award Letter		$
Unemployment or Disability		Award Letter		$
Workers Compensation		Award Letter		$
General Relief		Award Letter		$
Temporary Assistance for Needy Family (TANF)		Award Letter		$
Food Stamps/ Electronic Benefit Transfer (EBT)		Award Letter		$
Alimony		Award Letter		$
Child Support		Award Letter		$
Student Loans		Award Letter		$
Pension/ Annuities		Last Year's 1099		$
Interest Income		Last Year's 1099		$
Dividends		Last Year's 1099		$
Capital Gains				$
Gross Rental Income				$
Last Year's Tax Return				
Other				$

Total Monthly Income	$

COPIES ONLY

Financial Assistance Application

Acknowledgement of Information

Pursuant to the Federal law, I am applying for Financial Assistance under Citrus Valley Health Partners Financial Assistance policy. I understand the information requested in this application is required for eligibility under the policy to determine if assistance will be granted. I understand by signing this application, I am consenting to allow Citrus Valley Health Partners designated staff representative to verify the accuracy of my information submitted. The verification approval process may include but is not limited to accessing my credit report. I declare under penalty of perjury that the information provided is true and correct. I understand the Hospital may need information in addition to the information I am submitting today. I understand failure to submit the requested documentation within 30 days of the request may result in a denial of financial assistance. I understand that I may qualify for uncompensated care or a partial discount based upon my income. If I qualify for a partial discount, I agree to pay the Citrus Valley Health Partners any portion deemed due by me within 30 days. Failure to pay the discount balance may result in assignment to an outside agency.

Signature : _____ Date: _____

Should you have any questions regarding this application or if you need assistance filling out this application, please contact:

Patient Financial Services Department at (626)732-3100
Monday- Friday 8:00am-4:00pm

Please submit completed application and ALL required supporting documents to:

Emanate Health Partners
1325 N. Grand Ave. Suite 300
Covina, CA 91724