VISTA del MAR HOSPITAL

# APPLICATION FOR FINANCIAL ASSISTANCE

PATIENT NAME _____ SPOUSE_____
ADDRESS _____ PHONE_____

Contact Person & Telephone: _____
If Self-Employed, Name of Business: _____

Spouse Employer:_____ Position: _____
Contact Person & Telephone: _____
If Self-Employed, Name of Business: _____

**CURRENT MONTHLY INCOME**

| | | Patient | Other Family |
|---|---|---|---|
| | Gross Pay (before deductions) | | |
| *Add:* | Income from Operating Business (if Self-Employed) | _____ | _____ |
| *Add*: | Other Income: Interest and Dividends | | _____ |
| | From Real Estate or Personal Property | _____ | _____ |
| | Social Security | _____ | _____ |
| | Other (specify): | _____ | _____ |
| | Alimony or Support Payments Received | _____ | _____ |
| *Subtract:* | Alimony, Support Payments Paid | _____ | _____ |
| *Equals:* | Current Monthly Income | _____ | _____ |
| | Total Current Monthly Income (add Patient + Spouse) | _____ | _____ |
| | Income from above | _____ | _____ |

**FAMILY SIZE**

Total Family Members _____
(Add patient, parents (for minor patients), spouse and children from above)

| | Yes | No |
|---|---|---|
| Do you have health insurance? | ☐ | ☐ |
| Do you have other Insurance that may apply (such as an auto policy)? | ☐ | ☐ |
| Were your injuries caused by a third party (such as during a car accident or slip and fall)? | ☐ | ☐ |

When applying only for discount payment program eligibility, Vista del Mar Behavioral Healthcare Hospital may only request recent paystubs or income tax returns for documentation of income. Patients applying only for discount payment program eligibility may receive less financial assistance than what may be available under our charity care program.

By signing this form, I agree to allow Vista del Mar Behavioral Healthcare Hospital to check employment for the purpose of determining my eligibility for a financial discount, I understand that I may be required to provide proof of the information I am providing in the form of recent pay stubs or tax returns. Vista del Mar Behavioral Healthcare Hospital will consider other forms of proof of income if submitted.

_____ _____
(Signature of Patient or Guarantor) (Date)

_____ _____
(Signature of Spouse) (Date)