Kaweah Health

Financial Assistance Application

Instructions

1. Please complete all areas on the attached application form. If any area does not apply to you, write N/A in the space provided.
2. Attach an additional page if you need more space to answer any question.
3. Please submit most current:

a. Federal income tax return (Form 1040) from the most recent year. You must include all schedules and attachments as submitted to the Internal Revenue Service;

b. If income has decreased per reported income on your Federal Income Tax Return, please provide most recent income stubs for both spouses (if applicable) along with Federal Income Tax Return.

c. If you did not file a federal income tax return, please provide the following:

- Two (2) most recent paycheck stubs; and
  - If unemployed or do not receive payroll stubs, a written statement of need must be provided by the patient or patients representative attesting to their income and employment status as part of the application process.

4. If you receive any of the following:

   SSI / DISABILITY / UNEMPLOYMENT. Please attach proof of income along with Federal Income Tax Returns.

5. If you have no source of income we will need a letter stating how you support yourself. If you have no source of income we need a letter attesting to this from the person you stated you receive support from.
6. Kaweah Health makes all reasonable efforts to determine whether medical care would be either fully or partially paid for under other private or public health insurance. Consideration will be given to coverage offered through private health insurance, Medi-Cal, Medicare, California Children's Services, the California Health Benefit Exchange (Covered California), or other state-or county-funded programs designed to provide health coverage.
7. Application must be signed by all parties providing documentation.
8. Please note, the financial assistance policy does not apply to:

a. Future services are not accepted; services must be rendered before application can be processed.

b. Out of county residents are eligible for emergency cases only.

c. Kaweah Health Medical Group, Sequoia Health and Wellness Clinic, and Separately billable physician services such as a primary care physician or California Emergency Physicians (Emergency Room Physicians) are not applicable.

9. Mail Application to:

   Kaweah Health
   400 W. Mineral King Ave.
   Visalia, CA 93291
   Fax: (559) 635-6162

10. If you prefer to apply online please visit us at KaweahHealth.org/charity.

    If you have any questions please contact us at 559-624-2000.

Patient Financial Services

is located in the Acequia Lobby on the corner of Floral St. and Acequia Ave.

305 W. Acequia Ave.
Visalia, CA 93291

The Patient Financial Services Department is available to assist you with any questions concerning your application.

Telephone Hours

Monday – Thursday
8 a.m. - 5 p.m.

Friday
8 a.m. - 12:30 p.m.

Office Hours

Monday – Thursday
8 a.m. - 5 p.m.

Friday
8 a.m. - Noon

Phone: (559) 624-2000
Fax: (559) 635-6162
Email: mybill@KaweahHealth.org

kaweahhealth.org/charity

KH Rev. May 2022

Kaweah Health

Health is our Passion
Excellence is our Focus
Compassion is our Promise

Financial Assistance Application

Account #

Patient Name | Spouse Name

Date of Birth | Date of Birth

Parent/Responsible Party Name

ADDRESS | **TELEPHONE**

City | State | Zip | Home | Work

SOCIAL SECURITY NUMBER

Patient/Guarantor | Spouse

FAMILY STATUS

List all dependents that you support

Name	Age	Relationship
Name	Age	Relationship
Name	Age	Relationship
Name	Age	Relationship
Name	Age	Relationship
Name	Age	Relationship

EMPLOYMENT STATUS

Patient/Guarantor Employer | Position

Contact Person | Telephone

Spouse Employer | Position

Contact Person | Telephone

INCOME

	Patient/Guarantor	Spouse
1. Gross Wages & Salary/Year (before deductions)		
2. Self-Employment Income/Year		

OTHER INCOME

	Patient/Guarantor	Spouse
3. Interest & Dividends		
4. Real Estate Rentals & Leases		
5. Social Security		
6. Alimony		
7. Unemployment/Disability		
8. All Other Sources (attach list)		

Total Income (add lines 1 - 8 above) $ _____

UNUSUAL EXPENSES

Please provide information on any unusual expenses such as medical bills, bankruptcy, court judgments or settlements payments (attach list as needed).

Description	Amount
Description	Amount
Description	Amount

If partial financial assistance is granted, what is the monthly payment you can afford to pay the hospital/clinic? Amount $

I/we declare that all information provided is true and correct to the best of my/our knowledge. I/we authorize Kaweah Health to verify any information listed in this application.

Signature of Patient/Guarantor _____ Signature of Spouse _____

Date _____ Date _____