Orchard Hospital

Financial Assistance Application

Important information required with application

Proof of Income:

Kindly provide the following information or an explanation as to why this information is not available. Missing documentation may delay the processing of your application and could result in a denial for assistance.

Below is a listing of the proof of income documentation that is required for consideration

Type of Income	Required Documentation
Employment Income	• Copy of Individual tax return (Form 1040) for current tax year • Copy of two most recent paystubs
Self-Employment	• Copy of Individual tax return (Form 1040) for current tax year
Social Security/Retirement	• Copy of Individual tax return (Form 1040) for current tax year • Copy of Award Letter from Social Security Administration stating monthly payment • Copy of monthly payment notification from Social Security Administration
Disability	• Copy of Individual tax return (form 1040) for current year • Copy of Award Letter from disability stating monthly disability payment • Copy of monthly payment notification from disability
Unemployment	• Copy of Individual tax return (form 1040) for current year • Copy of Award Letter from unemployment stating weekly or monthly benefit amount • Copy of monthly payment notification from unemployment
Spousal/Child Support	• Copy of Individual tax return (form 1040) for current year • Copy of letter stating monthly award amount
Rental Property	• Copy of Individual tax return (form 1040) for current year
Investment Income	• Copy of Individual tax return (form 1040) for current year
Proof of Dependents	• Copy of Individual tax return (form 1040) for current year

Financial assistance is available to those with or without healthcare insurance. Please note that to qualify for assistance, patients with insurance must have incurred health care costs amounting to at least 10 percent of their family income, either at Orchard Hospital or with receipts if incurred elsewhere.

Our Patient Financial Assistance team will make every effort to process your application expeditiously. Please send your completed application and required documents within 20 days to:

Orchard Hospital
PO Box 97
Gridley, CA 95948

Orchard Hospital

FINANCIAL ASSISTANCE APPLICATION

Please Print All Information

Date of application: _____

1. FAMILY INFORMATION – please provide names of all people to be considered for financial assistance

Last Name	First Name	Middle Initial	Medical Record Number	Date of Birth (MM/DD/YYYY)
Last Name	First Name	Middle Initial	Medical Record Number	Date of Birth (MM/DD/YYYY)
Last Name	First Name	Middle Initial	Medical Record Number	Date of Birth (MM/DD/YYYY)

If the patient is a minor, please list parent(s)/guardian(s) as applicant and co-applicant

2. APPLICANT (GUARANTOR) INFORMATION

Relationship to patient ☐Self ☐Spouse/Domestic Partner ☐Parent ☐Other: _____	Marital Status ☐Single ☐Married/Domestic Partner ☐Divorced ☐Separated

Last Name	First Name	Middle Initial	U.S. Citizen ☐Yes ☐No

Date of Birth (MM/DD/YYYY)	Number of dependents (other than self & co-applicant)	Ages of Dependents	Home Phone (xxx)xxx-xxxx	Cell Phone (xxx)xxx-xxxx

Street Address (Do not list PO Box)	City	State	County	Zip

Current Employer	Street address, City, State	Position

*If you are not working, how long have you been unemployed?

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If you mark **YES to Married or Domestic Partner:** Please complete Section 3

3. CO-APPLICANT (GUARANTOR) INFORMATION

Relationship to Patient ☐Self ☐Spouse/Domestic Partner ☐Parent ☐Other: _____				
Last Name	First Name		Middle Initial	U.S. Citizen ☐Yes ☐No
Date of Birth (MM/DD/YYYY)	Number of dependents (other than self & co-applicant)	Ages of Dependents	Home Phone (xxx)xxx-xxxx	Cell Phone (xxx)xxx-xxxx
Street Address (Do not list PO Box)	City	State	County	Zip
Current Employer	Street address, City, State		Position	
*If you are not working, how long have you been unemployed?				

4. OTHER COVERAGE QUESTIONS – All answers pertain to the patient

		Check appropriate answer
1.	Is the patient applying for assistance with bills for: Past services: (Indicate Dates: _____) Future services: (Indicate Dates: _____)	☐Yes ☐No
2.	Does the patient have health insurance: If **yes**, please provide the following information: Health Insurance Name: _____ Subscribers Name: _____ Members/Patients Identification Number: _____ Group Number: _____ Group/Employer Name: _____ Effective Date: _____ Health Insurance Telephone Number: _____	☐Yes ☐No
3.	Is the patient eligible for a state medical assistance program? If yes, please provide the following information: Name of program: _____ County: _____ Patient Identification Number: _____	☐Yes ☐No

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4. OTHER COVERAGE QUESTIONS – All answers pertain to the patient (Continued)

		Check appropriate Answer
4.	Is the patient being treated for injuries covered by Workers Compensation? If **yes**, please provide the following information: Name of Work Comp Carrier: _____ Adjuster Name: _____ Adjusters Phone Number: _____ Injury Date: _____ Claim/Case Number: _____	☐Yes ☐No
5.	Is the patient being treated for injuries covered by Third Party Liability such as an Auto Insurance Company? If **yes**, please provide the following information: Name of Auto Insurance or Attorney: _____ Auto Insurance or Attorney Phone Number: _____ Injury Date: _____ Claim/Case Number: _____	☐Yes ☐No
6.	Is the patient a Victim of Crime? If **yes**, please provide the following information: Date of Injury: _____ Name of Case Worker: _____ Case Woker Phone Number: _____ Case Number: _____	☐Yes ☐No

5. INCOME INFORMATION

Monthly Income Sources	Applicant	Co-Applicant	Combined Monthly Income (Applicant + Co-Applicant)
Employment Income	$	$	$
Social Security	$	$	$
Disability	$	$	$
Unemployment	$	$	$
Spousal/Child Support	$	$	$
Rental Property	$	$	$
Investment Income	$	$	$
Other(s) use these spaces	$	$	$
		Total Combined Monthly Income	$

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Please print your name: _____

Signature: _____ Date: _____