CITY OF HOPE
FINANCIAL ASSISTANCE EVALUATION FORM

Instructions

As part of our commitment to serve the community, City of Hope provides financial assistance to patients who are in financial need and satisfy certain requirements.

Financial assistance is not considered to be a substitute for personal responsibility. Patient families are expected to cooperate by providing complete and accurate information so City of Hope can determine a patient's eligibility for our financial assistance program, and to contribute to the cost of the patient's care based on individual ability to pay.

Individuals who are eligible to apply for public assistance, as well as individuals with the capacity to purchase health insurance, will be encouraged to do so as a means of assuring access to health care services.

Please provide the following information and copies of supporting documentation with your Financial Assistance Evaluation Form:

- ☐ IRS Form W-2 and Earnings Statement of all household earnings
- ☐ Last two paycheck stubs for _____
- ☐ Most current bank statement(s)
- ☐ Income tax return for previous tax year
- ☐ Governmental assistance, Social Security or Workers Compensation Eligibility
- ☐ Unemployment or Disability compensation letter
- ☐ Alimony or support payments received
- ☐ Proof of U.S. Residency (U.S. Passport, Green Card/Visa, Driver's License, Social Security Card, etc.).
- ☐ Notarized letter indicating family member/friend supporting patient

In the event income verification is unavailable, please contact our office for further instructions.

Applications without income verification are considered incomplete and will not be processed.

Patient Name		**Spouse Name**	
Address			
		Phone	
Patient Social Security #		**Spouse Social Security #**	

For assistance completing the Financial Assistance Evaluation Form, please contact Financial Clearance Services at:

1500 E. Duarte Road, Duarte CA, 91010 or contact us by telephone at: (844) 936-4673

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A: Family Status (List all dependents that you support)

Name _____ Age _____ Relationship _____
Name _____ Age _____ Relationship _____
Name _____ Age _____ Relationship _____
Name _____ Age _____ Relationship _____
Total Family Size: _____

B: Employment and Occupation

	Patient	Spouse
Employer		
Position		
Contact Person		
Contact Phone		
If Self Employed, Name of Business		

C: Current Monthly Income

	Guarantor	Spouse
1. Gross Pay from Employment		
2. Income from operating business (self-employed)		
3. Other Income		
a. Interest and dividends		
b. From real estate or rental property		
c. Social Security		
d. Unemployment		
e. Disability		
f. Alimony or support payments received		
TOTAL (Please Add)		

D: Deductions

	Guarantor	Spouse
1. Alimony, support payments paid		

E: Total Monthly Income

	Guarantor	Spouse
Total in box C less total in box D		

By signing this form, I/we agree to allow COH to check employment and credit history for the purpose of determining my eligibility for financial assistance.

I/we affirm that all statements on this application are true to the best of my knowledge and belief.

_____
Signature of Patient or Guarantor Date

_____
Signature of Spouse/Domestic Partner Date

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Asset Declaration Form

Today's Date: _____

Patient Name: _____

MRN: _____

Please list the value of all assets excluding primary residence and vehicle(s) used for daily living (i.e., work, school, Dr. appointments). Do not include amounts held in patient retirement or deferred compensation plans such as 401k, IRA's, etc.

	Present Value	Held as owner or beneficiary	Held jointly or severally w/ another person % shared	If not held in owner's name, state whose name and relationship to member	How acquired? (Purchase, lease, gift, inheritance)
Property:					
Real Estate					
Lands					
Moveable Property:					
Vehicles other than primary					
Motorcycle					
Jewelry					
Recreational Vehicles					
Other Investments					
Investment in banks					
Investment in stock markets					
Investment in companies					
Insurance Policies					
Total:					

I/we affirm that all statements on this form are true to the best of my knowledge and belief:

_____

Signature of Patient or Guarantor Date

_____

Signature of Spouse/Domestic Partner Date