Hazel Hawkins
MEMORIAL HOSPITAL
SKILLED NURSING FACILITIES
HOME HEALTH AGENCY
San Benito Health Care District

San Benito Health Care District
A Public Agency
911 Sunset Drive
Hollister, CA 95023-5695
(831) 635-1146

PATIENT FINANCIAL ASSISTANCE APPLICATION

POLICY:

This program is to provide financial assistance to persons who have health care needs and are uninsured and are ineligible for any government programs.

REQUIREMENTS:

- A completed Financial Application
- Last 3 months of pay check stubs or income statements
- Last filed income tax return(less then 2 years old)
- Valid Medi-Cal denial and or Covered California denial
- Statements on any monetary assets (checking and savings bank statements, stocks, bonds, etc…)

NOTE: Application process is not a guarantee that you will be approved for the Financial Assistance program. Some type of payment must be rendered every month until the application is approved.

SIGNATURE:_____ DATE_____

FULL CHARITY CARE, DISCOUNTED CHARITY CARE AND HIGH MEDICAL CHARITY CARE
STATEMENT OF FINANCIAL CONDITION

APPLICANT'S NAME: _____ SPOUSE NAME: _____

ADDRESS: _____ PHONE: _____

ACCOUNT #: _____ SSN: _____

FAMILY STATUS (List all dependents that you support)

NAME	RELATIONSHIP	AGE	SEX
_____	_____	_____	___F ___M
_____	_____	_____	___F ___M
_____	_____	_____	___F ___M
_____	_____	_____	___F ___M
_____	_____	_____	___F ___M
_____	_____	_____	___F ___M

FAMILY SIZE

Total Family Members (add applicant, spouse and dependents from above): _____

EMPLOYMENT AND OCCUPATION

APPLICANT'S EMPLOYER: _____ POSITION: _____
CONTACT PERSON& TELEPHONE: _____
IF SELF EMPLOYED, NAME OFBUSINESS: _____
SPOUSE'S EMPLOYER: _____ POSTION: _____
CONTACT PERSON & TELEPHONE: _____
IF SELF EMPLOYED, NAME OF BUSINES: _____

CURRENT INCOME (Select One): Weekly___ Bi-Weekly___ Monthly___ Yearly ___Other___

CATEGORY	APPLICANT	SPOUSE	OTHER FAMILY MEMBERS
Gross Pay (before deductions):	$ _____	$ _____	$ _____
Public Assistance:	$ _____	$ _____	$ _____
Social Security:	$ _____	$ _____	$ _____
Unemployment Compensation:	$ _____	$ _____	$ _____
Alimony:	$ _____	$ _____	$ _____
Child Support:	$ _____	$ _____	$ _____
Military Family Allotments:	$ _____	$ _____	$ _____
Pension:	$ _____	$ _____	$ _____
Income from Dividends and Interest:	$ _____	$ _____	$ _____
Income from Rent, Real Estate or Property:	$ _____	$ _____	$ _____
TOTAL:	$_____	$_____	$_____

MEDICAL EXPENSES INCURRED AND PAID

Total patient's out-of-pocket costs incurred at this hospital in prior 12 months (net of any discounts or write-offs:
$ _____

Total patient and patient's family out-of-pocket medical expenses (including but not limited to, hospital services, physician service, drugs, and all other medical services) paid by the paitnet or patient's family in prior 12 months :
$ _____

IN ORDER FOR US TO CONSIDER YOUR REQUEST, YOU MUST INCLUDE THE FOLLOWING ITEMS:

- A COMPLETED FINANCIAL APPLICATION
- LAST 3 MONTHS OF PAY CHECK STUBS OR INCOME STATEMENTS
- LAST FILED INCOME TAX RETURN (LESS THEN 2 YEARS OLD)
- VALID MEDI-CAL DENIAL and or COVERED CALIFORNIA DENIAL
- STATEMENT ON ANY MONETARY ASSETS (CHECKING AND SAVINGS BANK STATEMENTS, STOCKS, BONDS, ETC...

NOTE: Application process is not a guarantee that you will be approved for the Charity Program. Some type of payment must be rendered every month until application is approved.

_____ Date _____
(Applicant's signature)

_____ Date _____
(Spouse's signature)