MemorialCare

Long Beach Medical Center
Miller Children's & Women's Hospital Long Beach
Orange Coast Medical Center
Saddleback Medical Center

Financial Assistance Application

I am applying for the following program(s)

☐ Charity Care ☐ Discount Payment ☐ Both

Note: Patients that only apply for discount payment program eligibility may receive less financial assistance than what may be available to them under the charity care program.

HOSPITAL ACCOUNT NUMBER(S): _____

Step 1: Tell us about yourself and your family

Guarantor		**Spouse**	
Address:		**Phone #:**	
Social Security number: Guarantor: _____ Spouse: _____			
If you are a recipient of any low-income government-funded assistance or program. Please check here ☐			

List all dependents that you support.		
Name	Age	Relationship

Step 2: Tell us about your income

Note: For patients applying only for discount payment program eligibility, we may only request recent paystubs or income tax returns for documentation of income. We may accept other forms of documentation of income but shall not require such other forms.

Employer	**Guarantor Employer**	**Spouse Employer**
	Name: _____ Phone number: _____	Name: _____ Phone number: _____
1. Gross Wages & Salary (before deductions)*	$	$
*Include (i) 2 recent consecutive paycheck stubs or (ii) your Federal income tax return for the calendar year in which the patient was first billed and your Federal income tax return for the calendar year 12 months prior to when the patient was first billed."		

MemorialCare

Long Beach Medical Center
Miller Children's & Women's Hospital Long Beach
Orange Coast Medical Center
Saddleback Medical Center

Step 3: Please read and sign this application

By signing below, I/We declare that all information provided is true and correct to the best of my/our knowledge. I/We authorize MemorialCare to verify any information in this application. I understand that Financial Assistance programs are a "Payor of Last Resort" and hereby assign to the facility all benefits due from any liability action, personal injury claims, settlements and any and all insurance benefits which may become payable, for illness or injury for which the facility or its subsidiaries provided care.

_____	_____	_____	_____
Signature of Patient/Guarantor	Date	Signature of Spouse	Date

Step 4: Reminders

Did you…

- ☐ complete all areas and write N/A if any area does not apply to you?
- ☐ attach an additional page if you need more space to answer any question?
- ☐ and your spouse, if married, complete and sign?
- ☐ include *all* required information and copy of attachments?
  - ☐Proof of Income
    - ☐ 2 recent consecutive paycheck stubs or
    - ☐ 2 recent Federal income tax returns (current year that patient was billed, and prior year).

When ready to submit, please send the application with the required documents to:

- ▶ MemorialCare, ATTN: FAA, P.O. Box 20894, Fountain Valley, CA 92728-0894 or

Email: pfsdocuments@memorialcare.org. If you have any questions, please call us at 1-877-323-0043.