PALOMAR HEALTH

Financial Assistance Application

Return to:

Bank of America Lockbox Service
Lockbox 748696
Los Angeles, CA 90074 – 8698

Fin (Account)#	

Please provide one or more of the following:

A. IRS Form W-2, Wage and Earnings Statement for all Household earnings
B. Last two pay check stubs for all household earnings
C. Prior year Tax Returns

And/Or Provide a copy of one of the following

A. Government Assistance, Social Security, or Worker's Compensation
B. Unemployment compensation letter

Patient Information:

Patient Name	
Date of Birth	
Social Security #	
Address	
City, State, Zip	
Phone #	

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Family Status:

List all dependents that you support: (if applicable)
Please check box if there are no dependents

Name	Age	Relationship

Work Status:

Employment and Occupation**:** (if applicable)
Please check box if Unemployed ☐

Employer Name	
Position	
Employer Phone Number	
Length of Employment	
Employer Address	
City, State, Zip	

If Self Employed, Name of Business:
_____

Current Monthly Income:

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	Patient/Responsible Party	Spouse
Gross Pay	$	$
Total Combined Monthly Income		
Total Spent on medical expenses in the last 12 months		

By signing this application, I agree to allow Palomar Health to contact my employer, bank, and other sources, as well as request a credit history for the purpose of determining my Charity Care eligibility. I understand that if I do not qualify for services under the Charity Care guidelines that I will be personally liable for the charges of the services rendered by Palomar Health. I understand that I am entering into a credit transaction. I authorize Palomar Health and/or agent of Palomar Health to access my personal credit profile, credit score, or any other information available from a qualified credit reporting agency.

Signature:_____

Printed Name:_____

Relationship to patient if signed by other than patient:_____

Date:_____ _____