Antelope Valley Medical Center

Financial Assistance Application

Antelope Valley Medical Center's Financial Assistance Program provides financial assistance to patients with medically necessary healthcare needs with low-income, uninsured or underinsured, ineligible for a government program, and is otherwise unable to pay for medically necessary care based on their individual family financial situation. Those who apply for discounted payment may receive less financial assistance than those who apply for charity care. To determine if a patient/guarantor qualifies for financial assistance, we need to obtain certain financial information. Your cooperation will allow us to give all due consideration to your request for financial assistance.

Name _____ Address_____

Date of Birth ___ /___ /___ Social Security _____ Phone number_____

Financial Account Number(s) _____

List Dependents:

Name	Relationship	Age

Number of dependents filed on tax return: _____

Wages/Income	**Monthly**	**Annual**
Self-Wages	_____	_____
Spouse/Domestic Partner Wages	_____	_____
Other Family Member Wages	_____	_____
Social Security/Disability Benefits	_____	_____
Military Family Allotments	_____	_____
Retirement/Pensions	_____	_____
Unemployment Benefits	_____	_____
Alimony/Child Support	_____	_____
Income from Rent, Dividends, Interest	_____	_____
Expenses	**Monthly**	**Annual**
Mortgage/Rent	_____	_____
Utilities	_____	_____
Auto Loans	_____	_____
Medical Bills	_____	_____
Phone/Internet	_____	_____
Food/Gas	_____	_____
Credit Cards	_____	_____
Child Care/Other	_____	_____

Please submit tax returns dated during 12 months and 4 paystubs within 6 months of the first bill date.

My signature attests that the information I have provided on this form is accurate and true to the best of my knowledge.

_____ _____ _____

Print Applicant Name Applicant Signature Date