Financial Assistance
Help With Your Medical Bills

What if I do not have health insurance?
All patients who do not have health insurance are eligible for discounts and payment plans. Discounts vary and are based on income and size. To receive discounts and payment plans, or to apply for other financial aid programs, you will need to fill out an application and meet certain requirements.

Is there help if my health insurance does not cover my bills?
Customer Services assists patients that have health insurance but who need additional financial resources to cover medical bills. We identify and help families apply for programs including:

- Medi-Cal/Medicaid
- Social Security
- Waivers
- Developmental Disabilities Services
- Bureau for Children with Medical Handicaps (BCMH)

Size of Fami-	100 Percent	110 Percent	125 Percent	150 Percent	175 Percent	185 Percent	200 Percent
1	$15,060	$16,566	$18,825	$22,590	$26,355	$27,861	$30,120
2	$20,440	$22,484	$25,550	$30,660	$35,770	$37,814	$40,880
3	$25,820	$28,402	$32,275	$38,730	$45,185	$47,767	$51,640
4	$31,200	$34,320	$39,000	$46,800	$54,600	$57,720	$62,400
5	$36,580	$40,238	$45,725	$54,870	$64,015	$67,673	$73,160
6	$41,960	$46,156	$52,450	$62,940	$73,430	$77,626	$83,920
7	$47,340	$52,074	$59,175	$71,010	$82,845	$87,579	$94,680
8	$52,720	$57,992	$65,900	$79,080	$92,260	$97,532	$105,440

For all states (except Alaska and Hawaii) and for the District of Columbia.

How do I apply for Financial Assistance?
To apply for financial assistance, please download the Confidential Medical Financial Assistance Application.

Please send your completed Financial Assistance form to the hospital where you received your services:

AHMC Anaheim Regional Medical Center

Attn: Director of Patient Services
1111 W La Palma Ave.
Anaheim, CA 92801

Garfield Medical Center

Attn: Director of Patient Services
525 N Garfield Ave.
Monterey Park, CA 91754

Greater El Monte Community Hospital

Attn: Director of Patient Services
1701 Santa Anita Ave.
South El Monte, CA 91733

Monterey Park Hospital

Attn: Director of Patient Services
900 S Atlantic Blvd.
Monterey Park, CA 91754

San Gabriel Valley Medical Center

Attn: Director of Patient Services
438 W Las Tunas Dr.
San Gabriel, CA 91776

Whittier Hospital Medical Center

Attn: Director of Patient Services
9080 Colima Road
Whittier, CA 90605-1898

Who should I contact if I have additional questions regarding Financial Assistance?

For more information, contact the hospital you visited:

- **AHMC Anaheim Regional Medical Center:** 714.774.1450
- **Garfield Medical Center:** 626.573.2222
- **Greater El Monte Community Hospital:** 626-579-7777
- **Monterey Park Hospital:** 626.570.9000
- **San Gabriel Valley Medical Center:** 626.289.5454

Whittier Hospital Medical Center: 562.945.3561

Financial Assistance Application

Whittier - Garfield - Monterey Park - Greater El Monte - Anaheim Regional - San Gabriel - Seton - Coastside

AHMC Healthcare 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. 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 _____ Account Number_____

Address_____ Phone number_____

_____ Social Security _____

Date of Birth ___/___/___ Sex____ M=Male F=Female Do you own a home? Yes ( ) No ( )

Number of dependents filed on tax return: _____ Do you own other property? Yes ( ) No ( )

List Dependents: Do you own automobiles? Yes ( ) No ( )

Name	Relationship	Age	Gender

Household Banking Information **Name**_____ **Balance**_____

Business Banking Information **Name**_____ **Balance**_____

Wages/Income	**Monthly**	**Annual**
Self Wages		
Spouse Wages		
Other Family Member Wages		
Social Security		
Unemployment Benefits		
Retirement / Pensions		
Alimony / Child Support		
Military Family Allotments		
Pensions		
Income from Rent, Dividends, Interest		
Expenses	**Monthly**	**Annual**
Mortgage / Rent		
Utilities		
Auto Loans		
Hospital Bills		
Telephone		
Food		
Credit Cards		
Gasoline		
Child Care		
Other		

Please send the most recent following supporting documentation: Income Tax Filings or W-2s, 3 Bank Statements, 4 Pay Check Stubs, and proof of expenses.

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

_____ _____ _____

Print Name **Signature** **Date**