# Salinas Valley Health Medical Center
# Financial Assistance Application

## INSTRUCTIONS

1. Please complete all areas on the attached application form. If any area does not apply to you write *N/A* in the space provided.

2. Attach an additional page if you need more space to answer any question.

3. Please provide proof of family income when you submit this application. The following documents are accepted as proof of income:

   **i. Paystubs within six (6) months before or after the patient is first billed; or**

   **ii. Income tax returns from the year the patient was first billed or 12 months prior to when the patient was first billed.**

If you have no income, you may provide a letter explaining how you support yourself and/or your family. Salinas Valley Health Medical Center may accept but does not require other forms of documentation of income.

4. Your application cannot be processed until all required information is provided.

5. You *must* sign and date the application. If the patient/guarantor and spouse provide information, both *must* sign the application.

6. If you have questions, please call your account representative at 831-755-0732.

7. Mail or deliver your completed application to:

Salinas Valley Health Medical Center
Patient Financial Services Department

3 Rossi Circle, Suite C
Salinas, CA 93907
831-755-0732

NS 8530-88 (Rev. 12123)

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# Financial Assistance Application

Please check the type of financial assistance you are interested in applying for (most patients will check both boxes):

☐ Full Charity Care
☐ Discount Payment: Patients applying only for the Discount Payment Program may receive less financial assistance than may be available under Charity Care

**ACCOUNT/MEDICAL RECORD #** (To be completed by SVHMC Staff): _____

| | |
|---|---|
| **PATIENT/ GUARANTOR NAME**: | _____<br>FIRST MI LAST |
| **SPOUSE NAME:** | _____<br>FIRST MI LAST |
| **PATIENT ADDRESS** | **PHONE NUMBER(S)** |
| Line 1: | Patient: |
| Line 2: | Spouse: |
| **SOCIAL SECURITY NUMBER (OPTIONAL)** | |
| Patient/ Guarantor: | Spouse: |

**LIST ALL FAMILY[1] MEMBERS**
(Attach separate sheet if needed)

| Name | Age | Relationship |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**EMPLOYMENT STATUS**
(Optional **ONLY** for Taylor Farms Family Health & Wellness Center Patients)

| | |
|---|---|
| **Patient / Guarantor Employer:** | Position/Title: |
| | Telephone: |
| Contact Person: | |
| **Spouse Employer:** | Position/Title: |
| | Telephone: |
| Contact Person: | |

[1] Family is defined as:

i) For persons 18 years of age and older, spouse, domestic partner, dependent children under 21 years of age, or any age if disabled, whether living at home or not, and

ii) For persons under 18 years of age or for a dependent child 18 to 20 years of age, parent, caretaker relatives, and other children under 21 years of age, or any age if disabled, of the parent or caretaker relative.

| FAMILY MONTHLY INCOME (MUST BE BELOW 400% OF FPL FOR ELIGIBILITY) | | |
|---|---|---|
| | Patient/Guarantor | Spouse |
| 1. Gross Wages & Salary / Year (before deductions) | | |
| 2. Self-Employment Income / Year | | |
| **Other Income:** | | |
| 3. Interest & Dividends | | |
| 4. Real Estate Rentals & Leases | | |
| 5. Social Security | | |
| 6. Alimony/Child Support | | |
| 7. Unemployment/Disability | | |
| 8. Public Assistance | | |
| 9. All Other Sources (attach list) | | |
| GROSS FAMILY INCOME | | |

By signing below, I/we declare that all information provided is true and correct to the best of my/our knowledge. I/we authorize Salinas Valley Health Medical Center to verify any information listed in this application. I/We expressly grant permission to contact my/our employer.

_____ _____

Signature of Patient / Guarantor Signature of Spouse

_____ _____

Date Date