APPLICATION FOR FINANCIAL ASSISTANCE

PATIENT NAME _____ SPOUSE_____

ADDRESS _____ PHONE_____

Contact Person & Telephone: _____

If Self-Employed, Name of Business: _____

Spouse Employer: _____ Position: _____

Contact Person & Telephone: _____

If Self-Employed, Name of Business: _____

	CURRENT MONTHLY INCOME	PATIENT	OTHER FAMILY
	Gross Pay (before deductions)		
	Income from Operating Business (If Self-Employed)		
Add:	Other Income:		
	Interest and Dividends		
	From Real Estate of Personal Property		
	Social Security		
	Other: _____		
	Alimony or Support Payments Received		
Subtract:	Alimony or Support Payments Paid		
Equals:	Currently Monthly Income		
	Total Currently Monthly Income (Add Patient + Other)		

FAMILY SIZE (Add patient, parents (for minor patients), spouse, children, and other family from above.)	

	Yes	No
Do you have health insurance?		
Do you have other Insurance that may apply (such as an auto policy)?		
Were your injuries caused by a third party (such as during a car accident or slip and fall)?		

When applying only for discount payment program eligibility, Aurora Behavioral Health Care San Diego may only request recent paystubs or income tax returns for documentation of income. Other forms of documentation of income may be requested, but may not require them. Patients applying only for discount payment program eligibility may receive less financial assistance than what may be available under our charity care program.

By signing this form, I agree to allow Aurora Behavioral Health Care San Diego to check employment for the purpose of determining my eligibility for a financial discount, I understand that I may be required to provide proof of the information I am providing in the form of recent pay stubs or tax returns. Aurora Behavioral Health Care San Diego will consider other forms of proof of income if submitted.

_____ _____

(Signature of Patient or Guarantor) (Date)

_____ _____

(Signature of Spouse / Other Family) (Date)