Attachment A

Phone (818) 787-2222 Ext 3131
Fax: (818) 904-3696

This application is for you to apply for Deanco Healthcare LLC, doing business with Mission Community Hospital Financial Assistance Program, which includes (1) Charity Care Program and (2) Discount Payment Program. The criteria for eligibility for these programs can be found in the Mission Community Hospital Charity Care and Patient Discount Payment Policies and Procedures.

Select the program you are applying for:

- ☐ Charity Care Program (free care)
- ☐ Discount Payment Program (reduced Charges)

To make your application complete, the following documentation must be included:

- Copy of a valid picture identification and or passport.
- Proof of Family income (most recent paystubs or current income tax returns only)
- Statement of support if there is no income

Failure to submit all required documentation with the application will result in an incomplete application. The application process takes approximately 30 days from the date the application was received.

Patients that apply for the Discount Payment Program may receive less financial assistance than what may be available under the Charity Care Program.

This application for the Discount Payment Program is for Mission Community charges only and does not apply to Professional Fees charges, which are billed separately by your provider, such as Physicians, Anesthesiologist, & Radiology etc. These charges will be your financial responsibility.

Mission Community Hospital

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Application for Financial Assistance

Patient Name: _____ Spouse _____

Address: _____Phone ( ) _____

City:_____State:_____Zip Code:_____

Email Address_____

Guarantor #: _____ Date of Birth _____

MRN: _____

Family Status:

- If the patient is 18 years or older, please list the following: spouse, domestic partner, dependents under age 21, and/or dependents of any age if disabled.

- If the patient is under 18 years of age or for a dependent child 18 to 20 years of age, please list the patient, caretaker relatives, and parent's or caretake' s relatives' other dependent children under 21 years of age, or any age if disabled.

(If additional space is needed, please use page 5)

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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Employment and Occupation

Employment: _____ Position: _____

If self-employed, Name of Business: _____

Spouse's Employment: _____ Position: _____

If self-employed, Name of Business: _____

Current Monthly

	Patient	Spouse
Monthly Gross Wages	$	$
Section A (Income-Unearned):		
Social Security Pension	$	$
Retirement or VA Benefits	$	$
Unemployment	$	$
Alimony or Child Support Payments Received	$	$

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Please agree to the following information

- **I declare under penalty of perjury that the answers I have given are true and correct to the best of my knowledge.**

- **I understand that I may be required to provide proof of the information I am providing.**

- **I further agree that in consideration for receiving health care services as a result of an accident or injury, to reimburse Deano Healthcare LLC, doing business with Mission Community Hospital from the proceeds of any litigation or settlement resulting from such act.**

_____ _____

(Signature of Patient or Guardian) (Date) **(Spouse Signature) (Date)**

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Additional Space for Comments: