

## 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:

<u>Name</u>	<u>Relationship</u>	<u>Age</u>

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 send the most recent following supporting documentation: Income Tax Filings and 4 Pay Check Stubs.**

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