Hazel Hawkins
MEMORIAL HOSPITAL

Application for Financial Assistance

Thank you for choosing Hazel Hawkins Memorial Hospital as your healthcare provider. This application has been provided to you to determine if you meet the Federal requirement for Financial Assistance (Free Care) at Hazel Hawkins Memorial Hospital. This application must be filled out completely. If we receive an incomplete application, it will be returned and cause a delay to the application processing time. If you have any questions or need help filling out this application, please call the Financial Assistance (Patient Financial Services) Department at **(831) 636-2620.**

Please include with your application the following documents:

- A copy of your Driver's License or State Identification.
- A copy of your Federal Income Tax return for the year in which the patient was first billed and the year before the patient was first billed.
- If no tax was filed, documentation of family income in the form of recent pay stubs within a 6-month period before or after the patient was first billed.
  If the patient is from out of the country, the hospital may request an affidavit to prove income eligibility.

When determining eligibility for Hospital's Financial Assistance, a spouse's income and assets will be used for adults. Parent(s) income and assets will be used for a minor child(ren).

Additional Application Instructions:

1. If the patient is a minor, the guarantor or guardian must provide his/her information.
2. If the patient is deceased, the executor of the estate or the legal guardian must provide his/her information or a death certificate.
3. One application per patient. The application is good for a period of three (3) months in the current year from date of service.
4. Completed application must be returned to us within thirty (30) days of issue. Cases can be reopened if documentation is received at a later date.

Section 1 – Personal Information

Today's Date _____/_____/_____

Date of Service/Visit: ____/____/_____

Patient Name (Last, First, MI) Social Security Number (Optional)

Street Address of Patient City, State, Zip Code

Patient Date of Birth: ____/____/_____

Telephone #: (____) _____-_____

Name of Guarantor (If other than patient): _____

Family Size: _____

Names Age Relationship

Employer/Company Name | Job Title | Length of Employment

Employer's Name | Contact Person | Telephone

Street Address | City/State/Zip

Does your employer offer medical insurance coverage? ☐ Yes ☐No
If yes, give reason why you are not covered? _____

Section 2- Source of income

		Weekly	Monthly	Yearly
Salary before deductions (Including Military)	$_____	☐	☐	☐
Public Assistance	$_____	☐	☐	☐
Social Security (and/or VA benefits)	$_____	☐	☐	☐
Alimony/Child Support	$_____	☐	☐	☐
Pension Payments/Dividends and Interest	$_____	☐	☐	☐
Rental/Real Estate income	$_____	☐	☐	☐
Other Monetary Support	$_____	☐	☐	☐
Grand Total of Income:	$_____			

Section 3 – Certification by Applicant

I, (Print Name) _____, understand that the information that I submit is subject to verification by Hazel Hawkins Memorial Hospital, its employees, and the Federal/State government. Intentional misrepresentation of these facts will make me liable for all hospital charges and subject to civil penalties. As requested by Hazel Hawkins Memorial Hospital, I certify that I have applied for Medi-Cal through the State of California and have attached with this application a copy of the denial letter. I certify that the above information regarding my family size, income, and assets is true and correct. I understand that it is my responsibility to advise Hazel Hawkins Memorial Hospital of any changes in status in regards to my income or assets while this application is in process.

_____ ____/____/_____

Signature of Applicant (Patient or Guarantor) Date

Please attach copies of all proof of income and assets with this application.