Charity Care/Financial Assistance Application Form – confidential

Please fill out all information completely. If it does not apply, write "NA." Attach additional pages if needed.

SCREENING INFORMATION
Do you need an interpreter? □ Yes □ No If Yes, list preferred language:
Has the patient applied for Medicaid? □ Yes □ No
Does the patient receive state public services such as TANF, Basic Food, or WIC? □ Yes □ No
Is the patient currently homeless? □ Yes □ No
Is the patient's medical care need related to a car accident or work injury? □ Yes □ No

PLEASE NOTE

- We cannot guarantee that you will qualify for financial assistance, even if you apply.
- Once you send in your application, we may check all the information and may ask for missing information.
- Within 21 calendar days after we receive your completed application and documentation, we will notify you if you qualify for assistance.
- This application is used to determine eligibility for both Charity Care (free care) and Discounted Care. If you only apply for Discounted Care, you may receive less financial assistance than what may be available under Charity Care

PATIENT AND APPLICANT INFORMATION

Patient first name	Patient middle name		Patient last name
□ Male □ Female □ Other (may specify) _____	Birth Date	□ Single □ Married □ Divorced □ Legally Separated □ Widow □ Widower	Patient Social Security Number (optional)
Facility:	Date of Service	Encounter Number	Preferred Contact Method: □ Email □Phone □ Mail
Person Responsible for Paying Bill	Relationship to Patient	Birth Date	Social Security Number (optional)

Mailing Address _____ _____ City State Zip Code	Main contact number(s) ( ) _____ ( )_____ Email Address: _____

Employment status of person responsible for paying bill
□ Employed (date of hire: _____)
□ Unemployed (how long unemployed: _____)
□ Self-Employed □ Student □ Disabled □ Retired □ Other (If Other Please Explain):
_____

FAMILY INFORMATION

List family members in your household, including you. "Family" includes people related by birth, marriage, or adoption who live together.

FAMILY SIZE _____

Name	Date of Birth	Relationship to Patient	If 18 years old or older: Employer(s) name or source of income	If 18 years old or older: Total gross monthly income (before taxes):	Also applying for financial assistance?
					Yes / No
					Yes / No
					Yes / No

Attach additional page if needed.
All adult family members' income must be disclosed. Sources of income include, for example:
- Wages - Unemployment - Self-employment - Worker's compensation - Disability - SSI
- Child/spousal support - Work study programs (students) - Pension - Retirement account distributions - Other (please explain_____)

INCOME INFORMATION

REMEMBER: You must include proof of income with your application.

You must provide information on your family's income. Income verification is required to determine financial assistance.
All family members 18 years old or older must disclose their income. If you cannot provide documentation, you may submit a written signed statement describing your income. Please provide proof for every identified source of income.
For purposes of determining eligibility for Financial Assistance, documentation of income shall be limited to:

- Recent pay stubs from within the 6 months before or after the patient is first billed (or in preservice when Application is submitted) or
- Copy of Federal Income Tax Return (Form 1040) for patient and spouse or domestic partner from the year the patient was first billed or 12 months prior to when the patient was first billed

You may submit other forms of proof of income if you wish, but no additional proof of income is required by Adventist Health. For example, if you have no proof of income or no income, you may attach an additional page with an explanation.

EXPENSE INFORMATION

We use this information to get a more complete picture of your financial situation.

Monthly Household Expenses:

Rent/mortgage $_____ Medical expenses $_____

Insurance Premiums $_____ Utilities $_____

Other Debt/Expenses $_____ (child support, loans, medications, other)

ADDITIONAL INFORMATION

Please attach an additional page if there is other information about your current financial situation that you would like us to know, such as a financial hardship, excessive medical expenses, seasonal or temporary income, or personal loss.

PATIENT AGREEMENT

I understand that Adventist Health may verify information by reviewing credit information and obtaining information from other sources to assist in determining eligibility for financial assistance or payment plans.

I affirm that the above information is true and correct to the best of my knowledge. I understand if the financial information I give is determined to be false, the result may be denial of financial assistance, and I may be responsible for and expected to pay for services provided.

_____ _____

Signature of Person Applying Date

For Questions, Please Call (844) 827-5047

Return Completed Form by Mail To:
Adventist Health
Attn: Patient Access 726 4th Street
Marysville, CA 95901

OR

Return Completed Form by Email To:
AHFinAsst@AH.org