

Discount Payment Financial Assistance Application Form

Provided in Accordance with Cal. Health & Safety Code § 127425(e)(5)

Application Date

MM-DD-YYYY

Date

Date of Service

MM-DD-YYYY

Date

Patient Name

First Name

Last Name

Account Number

Hospital

- [ ] Anaheim Global Medical Center
- [ ] Chapman Global Medical Center
- [ ] Orange County Global Medical Center
- [ ] South Coast Global Medical Center
- [ ] Hemet Global Medical Center
- [ ] Menifee Global Medical Center
- [ ] Victor Valley Global Medical Center

Address

Street Address

Street Address Line 2

City

State / Province

Postal / Zip Code

Phone Number

(000) 000-0000

Please enter a valid phone number.

Date of Birth

MM-DD-YYYY

Date

1) Was the patient a resident of California at the time of service?

- Yes
- No

2) Did the patient have medical insurance at the time of service?

- Yes
- No

3) Was the patient an active Medicaid recipient at the time of service?

Yes No

If you answered yes to questions 2) or 3), please upload a copy of your insurance or Medicaid card to this application.

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Income

Income is determined by patient's income 12 months prior to when the patient was first billed. "

see next page for revisions

	Family Member's Name	Age	Date of Birth	Relationship to Patient
1				
2				
3				
4				
5				
6				
7				
8				
9				

Income

Income is determined by patient's income 12 months prior to when the patient was first billed. For persons 18 years of age and older, a patient's family means a spouse, domestic partner (as defined in Section 297 of the Family Code), or dependent children under 21 years of age (or any age if disabled), whether living at home or not. For persons under 18 years of age, or for a dependent child 18 to 20 years of age, a patient's family means parents, caretaker relatives, and other dependent children under 21 years of age (or any age if disabled) of a parent or caretaker relative. Domestic Partner: (Family Code Section 297) (a) Domestic partners are two adults who have chosen to share one another's lives in an intimate and committed relationship of mutual caring; (b) A domestic partnership is established in California when both persons file a Declaration of Domestic Partnership with the Secretary of State, and, at the time of filing, all of the following requirements are met: (i) Neither person is married to someone else or is a member of another domestic partnership with someone else that has not been terminated, dissolved, or adjudged a nullity. (ii) The two persons are not related by blood in a way that would prevent them from being married to each other in this state. (iii) Both persons are at least 18 years of age, or, in the case of a minor, a court order is obtained in accordance with Section 297.1 of the Family Code. (iv) Both persons are capable of consenting to the domestic partnership.

Please upload additional family member information if applicable.



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Proof of income must be uploaded at the time of application (e.g., three months of pay stubs or most recent tax return (IRS form 1040), etc.).



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If you report $0 income, please upload a written statement of how you (or the patient) are surviving financially, include who provides food, shelter, transportation, etc. and how long you have been without income.



Browse Files

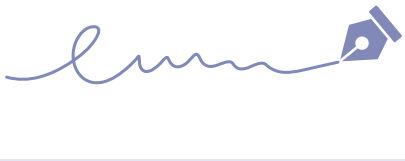
Drag and drop files here

Monthly Expenses

	Monthly Expense
Monthly Rent / Mortgage	
Utilities	
Car Payment	

Medical Expenses	
Insurance Premiums (life, home, car, medical)	
Clothing, groceries, household goods	
Other debt/expenses (e.g., child support, loans, other)	

My signature below certifies that everything I have stated on this application is correct and subject to review under audit. I understand, but if the information I provide is determined to be false, financial assistance may be denied, and I may be responsible for paying for the services provided.



Clear

For any questions regarding this form, please contact Central Business Office's Patient Financial Services at 800-270-0702.

Continue

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ACCESSIBILITY ENABLED FORM