Bakersfield Behavioral
HEALTHCARE HOSPITAL

APPLICATION FOR FINANCIAL ASSISTANCE

PATIENT NAME _____ SPOUSE_____
ADDRESS _____ PHONE_____

Contact Person & Telephone: _____
If Self-Employed, Name of Business: _____

Spouse Employer:_____ Position: _____
Contact Person & Telephone: _____
If Self-Employed, Name of Business: _____

CURRENT MONTHLY INCOME Patient Other Family

Gross Pay (before deductions)
Add: Income from Operating Business (if Self-Employed) _____ _____

Add: Other Income:
Interest and Dividends _____
From Real Estate or Personal Property _____ _____
Social Security _____ _____
Other (specify): _____ _____
Alimony or Support Payments Received _____ _____

Subtract: Alimony, Support Payments Paid _____ _____

Equals: Current Monthly Income _____ _____
Total Current Monthly Income (add Patient + Spouse) _____ _____
Income from above _____ _____

FAMILY SIZE
Total Family Members _____
(Add patient, parents (for minor patients), spouse and children from above)

	Yes	No
Do you have health insurance?	☐	☐
Do you have other Insurance that may apply (such as an auto policy)?	☐	☐
Were your injuries caused by a third party (such as during a car accident or slip and fall)?	☐	☐

By signing this form, I agree to allow Bakersfield Behavioral Healthcare Hospital to check employment for the purpose of determining my eligibility for a financial discount, I understand that I may be required to provide proof of the information I am providing in the form of recent pay stubs or tax returns. Bakersfield Behavioral Healthcare Hospital will consider other forms of proof of income if submitted.

_____ _____
(Signature of Patient or Guarantor) (Date)

_____ _____
(Signature of Spouse) (Date)