MAMMOTH HOSPITAL
Elevate Your Health

Financial Assistance Application - Instructions

If you need help paying your medical bill, you may be eligible for financial assistance from Mammoth Hospital ("MH"). To determine eligibility for financial assistance, please follow the instructions below to complete the Financial Assistance Application, including submission of supporting documentation, as applicable.

1. Documentation: For purposes of determining eligibility, please submit documentation of income limited to (i) paystubs within six months before or after the patient is first billed or (ii) income tax returns from the year the patient was first billed or 12 months prior to when the patient was first billed.

2. Submission: If you have questions, please call our Financial Counselors at (760) 924-4148.

Completed applications may be e-mailed to Billing@MammothHospital.com, faxed to (760) 934-1832, or mailed to: Mammoth Hospital, ATTN: Financial Counselors, PO Box 100 PMB 700, Mammoth Lakes, CA 93546

PATIENT FINANCIAL ASSISTANCE APPLICATION

DATE APPLICATION RECEIVED (to be completed by MH): _____

ACCOUNT/MEDICAL RECORD # (to be completed by MH): _____

PATIENT NAME: _____

Please check the type of financial assistance you are interested in applying for (most patients will check both boxes):

☐ Charity Care (Free)
☐ Discounted (Reduced) Care: Patients applying only for Discounted Care may receive less financial assistance than what may be available under Charity Care

Applicant Name: First_____Middle_____Last_____

Address: _____
Street/P.O. Box City State Zip Code

Phone Number(s): _____ Cell Phone Number(s): _____

Social Security #: _____ Date of Birth: _____

Employer: _____ Phone Number: _____

Occupation: _____ Hourly Rate of Pay $: _____

LIST ALL FAMILY MEMBERS (Use additional paper if needed)

Family is defined as:

i) For persons 18 years of age and older, spouse, domestic partner, dependent children under 21 years of age, or any age if disabled, whether living at home or not, and

ii) For persons under 18 years of age or for a dependent child 18 to 20 years of age, parent, caretaker relatives, and other children under 21 years of age, or any age if disabled, of the parent or caretaker relative.

NAME	RELATIONSHIP	AGE

MONTHLY INCOME (MUST BE BELOW 450% OF FPL FOR ELIGIBILITY)

	PATIENT/FAMILY INCOME
GROSS WAGES (before deductions)	

ESSENTIAL LIVING EXPENSES

Rent/Mortgage $_____	Utilities $_____	Food $_____
Child Support $_____	Alimony $: _____	Loans $_____
Insurance Premiums $: _____	Medical $_____	

By signing below, I/We declare that all information provided is true and correct to the best of my/our knowledge. I/We authorize Mammoth Hospital to verify any information listed in this application.

Patient Signature _____Date_____

Parent/Guardian _____ Date_____