Financial Assistance Application Form –
Confidential (Private)

Please fill out all information completely. If it does not apply, write "NA".

SCREENING INFORMATION
Select all that apply: Are you applying for Charity Care (i.e., free care)? □ Yes □ No Are you applying for Financial Assistance (i.e., reduced-price care)? □ Yes □ No
Do you need an interpreter? □ Yes □ No If Yes, list preferred language:
Is the patient currently homeless? ◘ Yes ◘ No
Has the patient applied for Medi-Cal? □ Yes □ No
Does the patient receive state public services such as EBT-SNAP, or WIC? □ Yes □ No
Is the patient's medical care related to a car accident or work injury? □ Yes □ No

PLEASE NOTE
For documentation of income, we only request recent paystubs or income tax returns. We accept, but do not require, other forms of documentation of income. **Patients applying only for Financial Assistance may receive less financial assistance than what may be available to them under the Charity Care program.** **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 additional information or proof of income.** **Within 14 calendar days after we receive your completed application and documentation, we will notify you if you qualify for assistance.**

PATIENT AND APPLICANT INFORMATION			
Patient First Name	Patient Middle Name	Patient Last Name	
Patient Sex Female ◘ Male ◘ Other (optional) ◘	Date of Birth	Patient Social Security Number (optional)	
Date of Service	Account Number(s)		
Person Responsible for Paying Bill	Relationship to Patient	Date of Birth	Main Contact number(s)
Home or Mailing Address	Preferred Contact Method: Phone ◘ Email ◘ Mail ◘	Email Address	
Employment Status of Person Who Needs to Pay the Bill ◘ Employed (date of hire):_____ ◘ Unemployed (for how long?):_____ ◘ Self-Employed ◘ Student ◘ Disabled ◘ Retired ◘ Other (if other, please explain): _____			

FAMILY INFORMATION

List family members in your household, including you. Patient's Family means the following: (1) For persons 18 years of age and older, spouse, domestic partner, as defined in Section 297 of the Family Code, and dependent children under 21 years of age, or any age if disabled, consistent with Section 1614(a) of Part A of Title XVI of the Social Security Act, whether living at home or not. (2) For persons under 18 years of age or for a dependent child 18 to 20 years of age, inclusive, parent, caretaker relatives, and parent's or caretaker relatives' other dependent children under 21 years of age, or any age if disabled, consistent with Section 1614(a) of Part A of Title XVI of the Social Security Act.

Total Family Size_____

Name of Each Family Member Living in Household	Date of Birth	Dependent of Person who needs to pay the bills	Total Income if older than 18 years old
		Yes No	
		Yes No	
		Yes No	
		Yes No	
		Yes No	
		Yes No	

TOTAL INCOME FOR ADULTS IN HOUSEHOLD

Total dependents for person(s) who needs to pay the bills	Total Income for adult family members	**You must disclose all adult family members' income. Sources of income include but are not limited to wages, unemployment, self-**
	$	**employment, and child support.**

TOTAL INCOME FOR ADULTS IN HOUSEHOLD

REMEMBER: You have to give us 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 and signed statement describing your income. Please provide proof for every identified source of income.

Proof of income means:

Recent pay stubs showing family income at the time of the first bill; or

• Last year's income tax return, including schedules,if applicable.

You may, but are not required to, provide additional proof of income beyond pay stubs reflecting family income at the time of the first bill and last year's income tax return.

If you have no proof of income or no income, please attach an additional page with an explanation.

Examples of proof of income include but are not limited to:

- A "W-2" withholding statement
- Recent pay stubs reflecting family income at the time of the first bill
- Last year's income tax return, including schedules if applicable
- Written, signed statements from employers or others
- Approval/denial letter of eligibility for Medicaid and/or state funded medical assistance
- Approval/denial letter of eligibility for unemployment payments

EXPENSE INFORMATION

We use this information to get a full idea of your financial situation.

Monthly Household Expenses:

Rent/Mortgage: $ Medical Expenses: $

Insurance Premiums: $ Utilities: $

Other Debt/Expenses: $ (child support, loans, medicine, other)

OTHER INFORMATION

Please attach another page if there is more information about your current financial situation that you would like us to know. This can be financial hardship, too many medical expenses, seasonal or temporary income, or personal loss.

PATIENT AGREEMENT

I understand that Monrovia Memorial Hospital 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 Charity Care or Financial Assistance, and I may be responsible for and expected to pay for the services provided.

_____

_____

Signature of Person Applying **Date**

For Questions, please call (626) 408-9800

Return Completed Form by Mail To:

Monrovia Memorial Hospital
323 South Heliotrope
Monrovia, California 91016

OR

Return Completed Application by Email To:

amandam@mmhosp.com