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Financial Assistance Application

Applicant (Guarantor) Information

Applicant Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Cell Number _____ Home Number _____

Marital Status: ❒ Married ❒ Single ❒ Divorced ❒ Widowed

Co-Applicant Information

Spouse/Domestic Partner Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Family (Household) Information

First, Middle, Last Name	Date of Birth	Relationship to Applicant
1		
2		
3		
4		

Income

Applicant		Co-Applicant	
Gross Income	$	Gross Income	$
Social Security / SSI / SSDI	$	Social Security / SSI / SSDI	$
Public Assistance	$	Public Assistance	$
Rental Property Income	$	Rental Property Income	$
Retirement/Pension	$	Retirement/Pension	$
Work Comp	$	Work Comp	$
Unemployment	$	Unemployment	$
Child Support	$	Child Support	$
Other	$	Other	$
Total	$	Total	$

Expenses

Applicant		Co-Applicant	
Life Insurance	$	Life Insurance	$
Medical Expenses	$	Medical Expenses	$
Other	$	Other	$
Property Tax	$	Property Tax	$
Phone/Cell Phone	$	Phone/Cell Phone	$
Utilities	$	Utilities	$
Total	$	Total	$

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Acknowledgement & Signature

ASSIGNMENT OF RIGHTS

By signing below, I declare under penalty of perjury that the information and statements contained in this Application for Financial Assistance, along with all submitted documentation, are accurate, true, and correct.

I understand that Hoag Hospital may reasonably request additional information and verification if necessary.

I acknowledge that the information and statements I have provided will be kept confidential by Hoag Hospital.

I understand that completing this application allows Hoag to consider my circumstances.

I also understand that Hoag makes no representation that financial assistance is guaranteed.

I/We hereby certify the above information and voluntarily authorize you to obtain credit information relative to me/us.

Applicant Signature	Date	Co-Applicant Signature	Date
_____		_____	

Application & Required Documents

Please select what you are applying for: ❒ Discount ❒ Financial Assistance (Charity Care)

Hoag uses one application for both discounted payment and financial assistance (charity care). It is important to know that if you only apply for a discounted payment, you may receive a smaller discount than what you could receive through the charity care program. The amount of help you get will depend on which program you qualify for.

In addition to the Financial Assistance Application, the following documents must be submitted:

- Two (2) pay stubs for each person in your home who earns wages, or a 1040 tax return for the year the patient was first billed, or for the 12 months before the billing date. Be sure to include all schedules and attachments.
- A copy of your most recent cancelled rent check, lease agreement, or mortgage payment. If someone like a family member or friend is giving you a place to live, or helping with your income, you may turn in a written statement from them instead.

Please send your application and all required documents using one of these options:

- **Secure Fax:** 949-764-7031
- **Email:** PFS@hoag.org
- **Mail:**
  Patient Financial Services
  2975 Red Hill Ave, Suite 200
  Costa Mesa, CA 92626

After we receive your completed application, we will send you a written decision within **30 days**.
If you have questions or want to talk about your account, please call **949-764-8400**.
Our office hours are **Monday through Friday, 8:00 AM to 4:30 PM**.