## APPLICATION FOR FINANCIAL ASSISTANCE

PATIENT NAME _____ SPOUSE'S NAME: _____
ADDRESS _____
PHONE NUMBER (_____) _____

CONTACT PERSON & PHONE NUMBER: _____
If Self-Employed, Name of Business _____

SPOUSE EMPLOYER _____ POSITION _____
CONTACT PERSON & PHONE NUMBER _____
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** (Add Patient, Parents (for minor patients), Spouse, and Children from Above**)**
Total Family Members _____

| | YES | NO |
|---|---|---|
| Do you have health insurance? | ☐ | ☐ |
| Do you have other insurance that might apply (such as auto policy)? | ☐ | ☐ |
| Were your injuries caused by a third party (a car accident, a slip, or fall)? | ☐ | ☐ |

When applying only for discount payment program eligibility, Aliso Ridge Behavioral Health may only request recent paystubs or income tax returns for documentation of income. Other forms of documentation of income may be requested, but may not require them. Patients applying only for discount payment program eligibility may receive less financial assistance than what may be available under our Free Care program.

By signing this form, I agree to allow Anaheim Community Hospital (ACH) 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. ACH will consider other forms of proof of income if submitted.

_____ _____ _____ _____
SIGNATURE DATE Signature of Spouse DATE

ANAHEIM COMMUNITY HOSPITAL

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PATIENT ID