

FINANCIAL ASSISTANCE APPLICATION INSTRUCTIONS

- 1. Please complete *all* areas on the attached application form. If any area does not apply to you, write N/A in the space provided.
- 2. Attach an additional page if you need more space to answer any question.
- 3. You must provide proof of income documents when you submit this application. The following documents are accepted as proof of income:

If you filed a federal income tax return you must submit a copy of:

a. Federal income tax return (Form 1040) from the most recent year. You must include all schedules and attachments as submitted to the Internal Revenue Service.

If you did not file a federal income tax return, please provide the following:

a. Two (2) most recent paycheck stubs.

If you have no income, or proof of income documents, we request that you please provide a letter explaining how you support yourself/family.

- 4. Your application for assistance cannot be processed until all required information is provided.
- 5. It is important that you complete and submit the Financial Assistance Application along with all required attachments as soon as possible so that LLUMC may determine your eligibility. Eligibility may be determined at any time LLUMC is in receipt of documentation.
- 6. You must sign and date the Financial Assistance Application. If the patient/responsible party and spouse provide information, both must sign the application.

7. If you have questions, please call the Patient Business Office at (909) 651-4177, between the hours of 9:00 a.m. and 5:00 p.m. Monday through Thursday, and 9:00 a.m. to 2:00 p.m. on Friday (excluding weekends and holidays). Weekends, holidays and after hours, please contact any Registration Representative for assistance.

8. Send your completed Financial Assistance Application and all documents to:

Loma Linda University Medical Center Patient Business Office P. O. Box 700 Loma Linda, CA 92354



Loma Linda University Medical Center FINANCIAL ASSISTANCE APPLICATION INSTRUCTIONS

PATIENT IDENTIFICATION

Page 1 of 3

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The purpose of this form is to determine patient/responsible party eligibility for financial assistance in accordance with the Loma Linda University Medical Center Charity Care/Discount Payment Policy.

| PATIENT/RESPONSIBLE PARTY (guarantor) NAME | SPOUSE NAME | |
|---|----------------|--|
| ADDRESS | PHONE Home: | |
| SOCIAL SECURITY NUMBER | | |

Patient/Responsible party _____

Spouse _____

FAMILY STATUS (List all dependents that you support)

| Name | Age | Relationship |
|------|-----|--------------|
| | | |
| | | |
| | | |
| | | |
| | | |

EMPLOYMENT STATUS

| Patient/Responsible | partv |
|---------------------|-------|
| | |

Employer

Patient/Responsible party

Position

Employer

Contact

Person

Employer Contact

Telephone

Spouse Employer

Spouse

Position

Employer

Contact

Person

Employer Contact

Telephone

LOMA LINDA UNIVERSITY MEDICAL CENTER Loma Linda University Medical Center FINANCIAL ASSISTANCE APPLICATION INSTRUCTIONS

Page 2 of 3

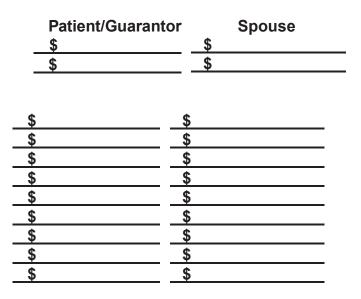
PATIENT IDENTIFICATION

19-0332 (7-24)

INCOME

- 1. Gross Wages & Salary/Year (before deductions)
- 2. Self-Employment Income/Year
- 3. Other Income:
- a. Interest & Dividends
- b. Real Estate Rentals & Leases
- c. Social Security
- d. Alimony
- e. Child Support
- f. Unemployment/Disability
- g. Public Assistance
- h. All Other Sources (attach list)

Total Income (add lines 1 - 3h above)



UNUSUAL EXPENSES

Please provide information on any unusual expenses such as medical bills, bankruptcy, court judgments or settlement payments (attach list as needed).

| Description | Amount |
|-------------|--------|
| | |
| | |
| | |
| | |
| | |

By signing below, I/we declare that all information provided is true and correct to the best of my/our knowledge. I/we authorize LLUMC to verify any information listed in this application. I/we expressly grant permission to contact my/ our employer.

| Signature of Patient/Responsible party | Relationship to Patient | Date | |
|---|-------------------------|------|--|
| Signature of Spouse | Date | | |
| Loma Linda University Medical Center | PATIENT IDENTIFICATION | | |

INSTRUCTIONS