GOOD SAMARITAN HOSPITAL – BAKERSFIELD

FINANCIAL ASSISTANCE APPLICATION

901 Olive Dr., Bakersfield, CA 93308 | 661-215-7799 | www.goodsamhospital.com

For assistance completing this form, please call 661-215-7799. Interpretation services available.

IMPORTANT: This application covers two separate programs.

1. **Charity Care (Full Assistance)** For patients with income at or below 200% of Federal Poverty Guidelines. May result in full write-off of your bill.

2. **Discounted Payment (Partial Assistance)** — For patients with income between 200%–400% of Federal Poverty Guidelines. Results in a discount on your bill.

Please note: If you only apply for Discounted Payment, you may receive less financial assistance than if you apply for Charity Care. We encourage you to apply for both programs so we can determine the maximum benefit available to you.

I am applying for: (check all that apply)

- ☐ **Charity Care (Full Assistance)**
- ☐ **Discounted Payment (Partial Assistance)**
- ☐ **Both programs (recommended)**

SECTION 1: PATIENT INFORMATION

Patient Last Name	Patient First Name	Middle Initial
Date of Birth	Account Number	Date of Service
Address	City	State / ZIP
Phone (Home)	Phone (Cell)	Email
Social Security Number (optional)	Preferred Language	

SECTION 2: HOUSEHOLD INFORMATION

Number of People in Household	Marital Status

List ALL household members (including yourself):

Name	Relationship	Date of Birth	Annual Income

SECTION 3: INCOME DOCUMENTATION

FOR DISCOUNTED PAYMENT APPLICANTS ONLY:

To determine eligibility for the Discounted Payment program, you must provide EITHER recent paystubs OR income tax returns (not both are required):

- ☐ Recent paystubs (within 6 months before or after your first bill date) — provide 2 pay stubs per wage earner
- ☐ Most recent income tax return (for the year you were first billed or 12 months prior)

FOR CHARITY CARE APPLICANTS:

In addition to paystubs or tax returns above, you may be asked to provide additional documentation to support your charity care application. The hospital will work with you on documentation if standard records are unavailable.

- ☐ Government program documentation (Medi-Cal, SSI, DHS, disability, etc.)
- ☐ Other income documentation (if applicable): ____________________________

Note: If you do not have documentation available, you may sign a self-attestation of income on this form. Financial information provided will NOT be used for debt collection purposes.

SECTION 4: SELF-ATTESTATION OF INCOME (if no documentation available)

I attest that my household's total monthly/annual income is approximately:

Monthly Household Income: $ ____________________	Annual Household Income: $ ____________________

SECTION 5: CERTIFICATION AND SIGNATURE

By signing below, I certify that the information provided in this application is true and accurate to the best of my knowledge. I authorize Good Samaritan Hospital to verify the information as needed to determine eligibility. I understand that:

- ☐ Financial information provided will not be used for debt collection activities.
- ☐ Applying for Discounted Payment only may result in less financial assistance than applying for Charity Care.
- ☐ If found eligible, coverage is valid for 6 months from the date of the eligibility letter.

Signature of Patient or Legal Representative	Relationship to Patient	Date
______________________	______________	______________

Printed Name
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Questions? Call our Business Office at 661-215-7799, Monday–Friday, or visit us at 901 Olive Dr., Bakersfield, CA 93308. Se habla español. Interpreter services available for other languages.