To apply in person please visit our office at 5855 Olivas Park Drive, Ventura, CA 93003
Monday – Friday, 9:00 am – 4:00 pm

REQUEST FOR FINANCIAL ASSISTANCE
UNCOMPENSATED CHARITY CARE / DISCOUNT PAYMENT PROGRAM
APPLICATION INSTRUCTIONS

Date: _____

Patient Name: _____

Account Number(s): _____

Total Balance for Consideration: $_____

This application is for Community Memorial Hospital charges only.

All physicians including Community Memorial Health Center physicians, radiologists, pathologists, anesthesiologists, emergency room physicians and ambulance services are billed separately from Community Memorial Hospitals and are not covered by this application.

The hospital may only request recent paystubs or income tax for documentation of income. The hospital may accept other forms of documentation of income but shall not require such other forms.

It is important that the application be complete, and all requested information is provided in order to properly assess your ability to pay all or part of the hospital bill.

Although we do not require a completed Medi-cal application to determine your eligibility; it is recommended that you complete a Medi-cal screening to offset any additional charges that is not covered by this application. If you choose to do so, you can contact the local Department of Health Services at 888-472-4463 or mybenefitscalwin.gov

The following documents are required to process your application:

(1) Fully completed charity care/discount payment program application (enclosed with this letter).

(2) Copies of your current period payroll check stubs for the last three months. Note that this also includes public assistance (for example, Social Security, Unemployment, or Disability). If you receive your income in cash, please provide us with a written statement from your employer stating your income.

If you currently are not receiving any income please write a brief paragraph on a separate sheet of paper stating your current financial situation. Be sure to include the date and signature. If you are receiving financial assistance or living with someone, please have him or her write a statement explaining the situation.

(3) Rent or mortgage verification.

(4) Copy of your prior 3 month's bank statements (savings, checking, IRAs, money market accounts, etc.).

(5) Copy of your prior year's tax return (the completed and signed 1040).

Please send copies of these documents because they will not be returned to you.
If you have any questions, please telephone me directly at 805-948-5676 for assistance.

Becky S.

Patient Financial Services Supervisor
Community Memorial Healthcare

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REQUEST FOR FINANCIAL ASSISTANCE
UNCOMPENSATED CHARITY CARE / DISCOUNT PAYMENT PROGRAM
APPLICATION

Patient Name: _____

Patient Account Number(s): _____

Guarantor Name_____

Date of Birth: _____SS#_____-_____-_____

Phone: ( ) _____

Address: _____

City, State, Zip: _____

Spouse Name: _____SS#_____-_____-_____

Are you a U.S. Citizen? _____Yes ___No

If not, a resident alien? _____Yes ___No

If not, non-resident alien? _____Yes ___No

FAMILY STATUS: List all dependents who you support

Name	**Age**	**Relationship**
1) _____	_____	_____
2) _____	_____	_____
3) _____	_____	_____
4) _____	_____	_____

EMPLOYMENT AND OCCUPATION

Employer: _____Position: _____

If self-employed, Name of business: _____

Employer Address: _____

Community Memorial HEALTHCARE

Phone Number: _____ How long employed: _____

Spouse Employer: _____ Position: _____

If self-employed, name of business_____

STATEMENT OF CURRENT INCOME AND EXPENDITURES

Current Monthly Income	**Patient**	**Spouse**
Gross Pay	$_____	$_____
Income from business (if self-employed) $_____	$_____	
Interest and dividends	$_____	$_____
Income from real estate or personal property	$_____	$_____
Social Security/Retirement Income	$_____	$_____
Alimony, support payments	$_____	$_____
Unemployment compensation	$_____	$_____
Other Income	$_____	$_____
Total Monthly Income	$_____	$_____
Current Monthly Expenses	**Patient**	**Spouse**
Rent or House Payment	$_____	$_____
Real Estate Taxes	$_____	$_____
Utilities	$_____	$_____
Alimony, support payments	$_____	$_____
Education	$_____	$_____
Food	$_____	$_____
Payroll Deductions	$_____	$_____
Medical, dental and medicines	$_____	$_____

Other_____	$_____	$_____
Total Monthly Expenses	$_____	$_____
Net Monthly Income after Expenses	$_____	$_____

I understand that Community Memorial Healthcare may verify my 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 financial assistance, and I may be responsible for and expected to pay for services provided.

_____ _____

(Signature of Patient or Guarantor) (Date)

_____ _____

(Signature of Co-applicant) (Date)