# Pioneers Memorial Hospital

## Financial Assistance Application

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### 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. Please note that based on eligibility, discount payment offers less financial assistance than charity care.

3. Attach an additional page if you need more space to answer any question.

4. 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 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. Three (3) recent paycheck stubs; and

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

5. Your application cannot be processed until *all* required information is provided.

6. It is important that you complete and submit the financial assistance application along with all required attachments.

7. You *must* sign and date the application. If the patient/guarantor and spouse provide information, both *must* sign the application.

8. If you have questions, please call your financial counselors at (760) 351-3322 and (760) 351-3323.

9. Send your completed application to:
   Pioneers Memorial Hospital
   Patient Financial Services Department
   207 West Legion Road
   Brawley, CA 92227

## Pioneers Memorial Hospital
## Financial Assistance Application

| | | | |
|---|---|---|---|
| **PATIENT/ GUARANTOR NAME** | | **SPOUSE NAME** | |
| | | | |
| **ADDRESS** | | **PHONE** | |
| | | Home | |
| | | Work | |
| | | | |
| **SOCIAL SECURITY NUMBER (optional)** | | | |
| **Patient/ Guarantor** | | **Spouse** | |

| **FAMILY STATUS**<br>**List all dependents that you support** | | |
|---|---|---|
| | | |
| **Name** | **Age** | **Relationship** |
| | | |
| | | |
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| | | |
| | | |
| | | |
| | | |
| | | |

| **EMPLOYMENT STATUS (optional)** | |
|---|---|
| | |
| **Patient/Guarantor Employer** | **Position** |
| | |
| **Contact Person** | **Telephone** |
| | |
| **Spouse Employer** | **Position** |
| | |
| **Contact Person** | **Telephone** |
| | |

| **INCOME** | | |
|---|---|---|
| | | |
| | **Patient/Guarantor** | **Spouse** |
| **1. Gross Wages & Salary/Year (before deductions)** | | |
| | | |
| **2. Self-Employment Income/Year** | | |
| | | |
| **3. Other Income:** | | |
| **3. Interest & Dividends** | | |
| **4. Real Estate Rentals & Leases** | | |
| **5. Social Security** | | |
| **6. Alimony** | | |
| **7. Child Support** | | |
| **8. Unemployment/Disability** | | |
| **9. Public Assistance** | | |

| | | |
|---|---|---|
| **10. All Other Sources (attach list)** | | |
| **Total Income (add lines 1 - 10 above)** | | |

| **UNUSUAL EXPENSES (optional)** | |
|---|---|
| | |
| **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 Pioneers Memorial Healthcare District to verify any information listed in this application. We expressly grant permission to contact my/our employer.

_____ _____

Signature of Patient/Guarantor Signature of Spouse

_____ _____

Date