FINANCIAL ASSISTANCE PROGRAM

P: 1-415-925-7070

Name: ______________________________ Date: ____________________

Account Number(s): ____

Dear Patient,

In order to process your application for financial assistance, please include the following information with your completed application:

- Copies of your 2 most recent pay stubs
  - *If unemployed:* Copy of monthly unemployment check
  - *If disabled/retired:* Copy of monthly social security/disability check
- Most Current Federal Tax Return (if self-employed, please include all schedules)
- Copies of bank statements for the most recent 2 months
- If you claim no income, you must provide documentation for how you support yourself

In the event that a Financial Assistance Application is received, but only partially completed, we will send you a request for the documentation necessary. Please note that until **all** requested information has been supplied, we will not submit your application for review, and you will continue to be billed for the total amount due.

Please return this information **<u>within 25 days</u>** from the date of this letter. Please be sure to include the department that your information is to be forwarded to:

Mail: MarinHealth Medical Center
Attn: Financial Assistance Department
3950 Civic Center Drive, Suite 200
San Rafael, CA 94903

Fax: 1-415-507-0713
Attn: Financial Assistance Department

We appreciate your timely response.

Sincerely,

Patient Financial Services

Helpful Hints

- If unable to provide something which has been requested, please send a letter explaining why.
- Your bank statement must show all deposits/withdrawals. If your deposits do not match your stated income, please explain why.
- If you are self-employed, please send in both personal/business bank statements.
- Please be sure to submit all information requested for both you, and your spouse.

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STATEMENT OF FINANCIAL CONDITION

PATIENT NAME ______________________________

ADDRESS ______________________________

ACCOUNT NUMBER(S) ______________________________

SPOUSE ______________________________

PHONE ____________________ SSN ____________________

FAMILY STATUS (List all dependents that you support)

NAME	*AGE*	*RELATIONSHIP*

EMPLOYMENT AND OCCUPATION

EMPLOYER ______________________________

POSITION ______________________________

CONTACT PERSON & TELEPHONE ______________________________

IF SELF EMPLOYED, NAME OF BUSINESS ______________________________

SPOUSE'S EMPLOYER ______________________________

SPOUSE'S POSITION ______________________________

SPOUSE'S CONTACT PERSON & TELEPHONE ______________________________

IF SELF EMPLOYED, SPOUSE'S NAME OF BUSINESS ______________________________

CURRENT MONTHLY INCOME (Add gross pay before tax/deductions)

	PATIENT	*SPOUSE*
ADD OTHER INCOME	______________	______________
INTEREST % DIVIDENDS FROM REAL ESTATE/PROPERTY	______________	______________
SOCIAL SECURITY	______________	______________
OTHER (PLEASE SPECIFY)	______________	______________
ALIMONY, SUPPORT PAYMENTS RECEIVED	______________	______________
SUBTRACT	______________	______________
ALIMONY, SUPPORT PAID OUT	______________	______________
EQUALS	A______________	B______________
TOTAL INCOME	______________ (A+B)	

FAMILY SIZE
ADD PATIENT, SPOUSE, & DEPENDENTS FROM ABOVE ______________

PATIENT:
ARE YOU INSURED? YES NO IF YES, PLEASE INDICATE ______________

DO YOU HAVE OTHER INSURANCE THAT MAY APPLY? (IE. AUTO POLICY) YES NO IF YES, PLEASE INDICATE ______________

WERE YOUR INJURIES CAUSED BY A THIRD PARTY? (IE. CAR ACCIDENT, SLIP & FALL) YES NO IF YES, PLEASE INDICATE ______________

____
PATIENT SIGNATURE

____
SPOUSE SIGNATURE

DATE ______________