Revised 11/24/2025

CHARITY CARE APPLICATION

SECTION 1: PATIENT DEMOGRAPHICS

Patient's Name: _____ Social Security#: _____
FIRST LAST

Current Address: _____ Birth Date: _____
STREET ADDRES CITY STATE Zip Code

Place of Birth: _____

Current Phone #:_____

1) Have you applied for MediCal or other government assistance in the last 6 months? YES / NO

If yes, were you awarded assistance? YES / NO If no, why were you denied? _____

2) Are you able to pay any portion of this bill? YES / NO If yes, how much? _____

3) Were the medical services related to an accident or third party injury? YES / NO

If yes, describe how the accident/injury occurred and the party who is responsible for covering the losses incurred resulting from the incident.

Pursuant to Federal law, I am applying for Charity Care Financial Assistance under Pomona Valley Hospital Medical Center's Charity Care Financial Assistance policy. I understand the information requested in this application is required for eligibility under the policy to be determined and assistance granted. By signing this application, I am consenting to allow the Hospital's designated staff and/or agent to verify the accuracy of the information submitted. The verification process may include but is not limited to accessing my credit report. I declare under penalty of perjury that the information I have provided is true and correct. I understand the Hospital may need information in addition to the information I am submitting today. I understand I may qualify for charity care discount based upon my income. Failure to pay the discount balance may result in assignment to an outside collection agency.

Signature: _____ Date: _____

Should you have questions regarding this application, contact:

PVHMC's Eligibility Services Department 909-865-9501.

Submit completed application and required document to:

PVHMC Eligibility Services
1798 North Garey Avenue
Pomona, CA 91767

SECTION 2: FAMILY SIZE

List all persons living in your household, their date of birth, social security# and relationship to patient.

	NAME	DATE OF BIRTH	SOCIAL SECURITY#	RELATIONSHIP TO PATIENT
1				
2				
3				
4				
5				
6				

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SECTION 3: MONTHLY INCOME

Briefly describe your employment status including date of hire and/or last date of employment/retirement. If you are receiving income from other sources, describe the type of support, the date support began and the date the support is expected to end, if applicable. Also describe any other pertinent details about your income.

Identify ALL sources of monthly income for your household. Enter the person receiving the income, the amount received each month for each income category applicable. In addition to completing this application, for each type of income you identify below, submit current pay stubs and/or tax returns.

		NAME: First Last	NAME: First Last
	Required Documentation	OCCUPATION:	OCCUPATION:
Wages	2 current pay stubs		
Hourly Rate			
Average Monthly Hours Worked			
Self employment gross receipts	YTD P&L Schedule (1)		
Partnership income	YTD P&L Schedule (1)		
Social Security	Award letter		
Supplemental Security Income (SSI)	Award letter		
Unemployment	Award letter		
Disability	Award letter		
Workers Compensation	Award letter		
General Relief	Award letter		
Temporary Assistance for Needy Families (TANF)	Award letter		
Food Stamps/Electronic Benefit Transfer (EBT)	Award letter		
Alimony	Award letter		
Child support	Award letter		
Student Loans	Award letter		
Pension/Annuities	last year's 1099		
Interest income	last year's 1099		
Dividends	last year's 1099		
Capital Gains	last year's 1099		
Gross Rental Income			
Other:			
TOTAL MONTHLY INCOME			

(1) YTD P&L Statement means the current year-to-date profit & loss statement for the business/partnership

If your family does not have income, in the space below, please describe how you have been able to meet your needs for food & shelter. If another person has been providing support, in addition to the explanation below, please ask the person to send PVHMC a letter describing the type of support, frequency and duration of the support.

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SECTION 4: MONTHLY EXPENSES

	NAME: First	NAME: Last	NAME: First	NAME: Last
Mortgage of owner occupied residence				
Mortgage of rental property				
Rent				
Property Taxes				
Car Payment				
Childcare				
Utilities & cell phone				
Food & household supplies				
Car insurance & gas				
Clothing				
Medical & dental expenses				
Insurance				
Credit Card Payments				
Tuition				
Child Support				
Spousal Support				
Installment payments				
Laundry & leaning expenses				
Other:				
TOTAL MONTHLY EXPENSES				

If the reported monthly expenses exceed reported income, explain how you are able to meet these financial obligations.

SECTION 5: PROPERTY, INVESTMENTS & SAVINGS

	Optional Documentation	NAME: First	NAME: Last	NAME: First	NAME: Last
Value of Home (if owned)					
Debt on Home (if owned)					
Value of Vehicles (Car, motorcycle, truck, etc.)					
Debt on Vehicles					
Checking account balance					
Savings account balance					
Non-retirement investment balance					
Retirement investment balance					
Assets of business or partnership					
Other:					
TOTAL ASSETS					

If the average monthly deposits exceed reported monthly income, explain the source of deposits and submit supporting documentation.