COLLEGE MEDICAL CENTER

Patient Name: Patient Financial Number:

FINANCIAL ASSISTANT APPLICATION

Schedule of Current Income and Expenditures

Patient's Name Spouse's Name

Address

Phone

Social Security Number: (Patient) (Spouse)

EMPLOYMENT AND OCCUPATION

Employer

Position

Contact Person

If self-employed, give name of business

Spouse's Employer

Position

Contact Person

If self-employed, give name of business

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Patient Name: Patient Financial Number:

CURRENT MONTHLY INCOME

	Patient	Spouse
Gross pay from employment: (Before deductions)	$ _____	$ _____
Income from operating business: (If self-employed)	$ _____	$ _____
Tax Return:	$ _____	$ _____
Total current monthly income: (Add all figures from above)	$ _____	$ _____

NO INCOME AFFIDAVIT – Must initial the statement below. I, _____, herby certify that I have no job or assets, and no income other than potential donations from others.
Parent/Guarantor Initials _____

ASSETS AND DEBTS

Please provide your best estimate of the value of any homes, cars or similar assets. Also, indicate how much debt you currently have.

Assets:

a. Home and Property: $ _____

b. Automobiles: $ _____

c. Retirement plan: $ _____

Investments/other (specify): $ _____

Debts:

a. Amount owed on mortgages: $ _____

b. Amount owed on automobiles: $ _____

c. Amount owed on credit cards: $ _____

d. Other: $ _____

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FAMILY STATUS

List all dependents you support

Name	Age	Relationship

I certify that the above stated information is true and correct. I authorize Glendora Hospital to contact the employer's institutions on this application or a credit reporting agency to verify its accuracy. I further authorize the employers, institutions and/or credit reporting agencies to release such information to College Hospital.

(Date) (Signature of Patient or Guarantor)

(Date) (Signature of Spouse)

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Financial Assistance Application Instructions

1. Please complete all areas on the attached application form. a. If any area does not apply to you, write N/A in the space provided.
2. Attach an additional page if you need more space to answer any question.
3. Proof of income is required when you submit this application. The following documents are accepted as proof of income:
   a. Two (2) most recent paycheck stubs;
   b. Federal W-2 Form showing wages and earnings
   c. Social Security Monthly Income Statement
   d. If you are paid only in cash, please provide a written statement explaining your income sources.
4. If you have no income, please complete and initial the NO INCOME AFFIDIVIT on page 2 of the application.
5. You must provide three (03) consecutive bank statements. Ensure all accounts and complete statements (all pages) are provided.
6. It is important that you complete, sign and submit the financial assistance application along with all required attachments within fourteen (14) days.
7. You must sign and date the application.
8. Your application cannot be processed until all required information is provided. Your completed application can be mailed or emailed to the addresses below:

COLLEGE MEDICAL CENTER
PO BOX 16421
LONG BEACH, CA 90806
ATTN: BUSINESS OFFICE

COLLEGE MEDICAL CENTER

For any questions, please ***Contact: Business Office directly at 562-256-8314.*** Thank you in advance for your courtesy and prompt attention regarding this matter.