Hospital Financial Assistance Application

Patient Name: ____ **Admission#** ___________
Address ____ **Phone** ________________
Dependents and Income

Name	Birthdate	Relationship

Monthly Family Income

Father's Employment ______________________
Mother's Employment ______________________
Dividends, Interest _______________________
Retirement Income __________________ _____
Alimony ___________________________________
Child Support _____________________________
Worker's Comp ____________________________
Social Security ____________________________
Unemployment ____________________________
Public Assistance __________________________
Other (specify) ____________________________
Grand Total $ ____________________________

All Income from Household must be reported
Proof of Income:
If you filed a federal income tax return:

- Federal income tax return (1040) from last 2 years, including all schedules and attachments
- W-2 Form showing wages and earnings

If you did not file a federal income tax return:

- Two (2) most recent paycheck stubs
- Two (2) most recent check stubs from SSI, child support, unemployment, disability, alimony or other qualified payments
- Two (2) consecutive bank statements

Monetary Assets

Cash on hand/Money in bank, savings, etc. $ ______________________________
Stocks/bonds/securities (Cash Value) $ ______________________________
Cash Value of real estate $ ______________________________

Monthly Expenses

Automobiles	Car "A"	Car "B"	Car "C"
Year ____________			
Make ____________			
Model ____________			

Balance Owing ____
Rent/Mortgage ____
Other (specify) ____

I affirm that the above information is true and correct and authorize HealthBridge Children's Hospital to obtain and verify all information reported above including but not limited to my account information from financial or commercial institutions, IRS, employers and other entities for the purpose of determining financial assistance eligibility for the above hospital admission.

Applicant's Signature ________________________________ Date ______________

Hospital Representative ______________________________ Date ______________

393 S. Tustin St. / Orange, California 92866 / 714.289.2400 phone