



Long Beach Medical Center  
 Miller Children's & Women's Hospital Long Beach  
 Orange Coast Medical Center  
 Saddleback Medical Center

**Financial Assistance Application**

I am applying for the following program(s)

- Charity Care     Discount Payment     Both

Note: Patients that only apply for discount payment program eligibility may receive less financial assistance than what may be available to them under the charity care program.

**HOSPITAL ACCOUNT NUMBER(S):** \_\_\_\_\_

**Step 1: Tell us about yourself and your family**

<b>Guarantor</b>		<b>Spouse</b>	
<b>Address:</b>		<b>Phone #:</b>	
<b>Social Security number:</b> Guarantor: _____		Spouse: _____	
If you are a recipient of any low-income government-funded assistance or program. Please check here <input type="checkbox"/>			

List all dependents that you support.		
Name	Age	Relationship

**Step 2: Tell us about your income**

Note: For patients applying only for discount payment program eligibility, we may only request recent paystubs or income tax returns for documentation of income. We may accept other forms of documentation of income but shall not require such other forms.

Employer	Guarantor Employer	Spouse Employer
	Name: _____ Phone number: _____	Name: _____ Phone number: _____
1. Gross Wages & Salary (before deductions)*	\$ _____	\$ _____

\*Include (i) 2 recent consecutive paycheck stubs or (ii) your Federal income tax return for the calendar year in which the patient was first billed and your Federal income tax return for the calendar year 12 months prior to when the patient was first billed."



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### Step 3: Please read and sign this application

By signing below, I/We declare that all information provided is true and correct to the best of my/our knowledge. I/We authorize MemorialCare to verify any information in this application. I understand that Financial Assistance programs are a "Payor of Last Resort" and hereby assign to the facility all benefits due from any liability action, personal injury claims, settlements and any and all insurance benefits which may become payable, for illness or injury for which the facility or its subsidiaries provided care.

\_\_\_\_\_  
Signature of Patient/Guarantor

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Spouse

\_\_\_\_\_  
Date

### Step 4: Reminders

Did you...

- complete all areas and write N/A if any area does not apply to you?
- attach an additional page if you need more space to answer any question?
- and your spouse, if married, complete and sign?
- include *all* required information and copy of attachments?
  - Proof of Income
    - 2 recent consecutive paycheck stubs or
    - 2 recent Federal income tax returns (current year that patient was billed, and prior year).

When ready to submit, please send the application with the required documents to:

▶ MemorialCare, ATTN: FAA, P.O. Box 20894, Fountain Valley, CA 92728-0894 or

Email: [pfsdocuments@memorialcare.org](mailto:pfsdocuments@memorialcare.org). If you have any questions, please call us at 1-877-323-0043.