APPLICATION FOR FINANCIAL ASSISTANCE

PATIENT NAME _____ SPOUSE'S NAME: _____
ADDRESS _____
PHONE NUMBER (_____) _____

CONTACT PERSON & PHONE NUMBER: _____
If Self-Employed, Name of Business _____

SPOUSE EMPLOYER _____ POSITION _____
CONTACT PERSON & PHONE NUMBER _____
If Self-Employed, Name of Business _____

CURRENT MONTHLY INCOME		Patient	Other/Family
	Gross Pay (before deductions)	_____	_____
(Add)	Income from Operating Business (if Self-Employed)	_____	_____
(Add)	Other Income: Interest and Dividends		
	From Real Estate or Personal Property	_____	_____
	Social Security	_____	_____
	Other (specify):	_____	_____
	Alimony or Support Payments Received	_____	_____
(Subtract)	Alimony, Support Payments Paid	_____	_____
(Equals)	Current Monthly Income	_____	_____
	Total Current Monthly Income (add Patient + Spouse) Income from above	_____	_____

FAMILY SIZE (Add Patient, Parents (for minor patients), Spouse, and Children from Above**)**
Total Family Members _____

	YES	NO
Do you have health insurance?	☐	☐
Do you have other insurance that might apply (such as auto policy)?	☐	☐
Were your injuries caused by a third party (a car accident, a slip, or fall)?	☐	☐

By signing this form, I agree to allow Anaheim Community Hospital (ACH) to check employment for the purpose of determining my eligibility for a financial discount, I understand that I may be required to provide proof of the information I am providing in the form of recent pay stubs or tax returns. ARBH will consider other forms of proof of income if submitted.

_____ _____ _____ _____
SIGNATURE DATE Signature of Spouse DATE

ANAHEIM COMMUNITY HOSPITAL

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PATIENT ID