Mountain View Child Care, Inc. *1720 Mountain View Ave.* *Loma Linda, CA 92354* ☒**Totally Kids Rehabilitation Hospital** ☐**Circlebrook**	Name_____ MR#_____ DOB_____ Physician_____

Hospital Financial Assistance Application

1. Please complete all areas on the attached application form. 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. You must provide proof of identity. The following documents are accepted as proof.
    a. California driver's license
    b. Identification card issued by the department of Motor Vehicles
    c. U.S citizenship or alien status documents (passport)
    d. Social Security card or document containing a social security number

4. You must provide proof of income documents when you submit this application. The following documents are accepted as proof of income.
    a. Tax return
        i. If you filed a federal income tax return, you must submit a copy of:
            1. Federal income tax return (1040) from the most recent year. You must include all schedules and attachments as submitted to the Internal Revenue Service.
        ii. If you did not file a federal income tax return, please provide the following:
            1. Two (2) most recent paycheck stubs; and
            2. A letter explaining why you do not file a federal income tax return
    b. Two most recent pay stubs
    c. If you have no income, or proof of income documents, please provide a letter explaining how you support yourself/family.

5. Your application for assistance cannot be processed until all the required information is provided.

6. It is important that you complete and submit the Financial Assistance Application along with all required attachments within fourteen (14) days.

7. You must sign and date the Financial Assistance Application. If the patient and/or responsible party and spouse provided information, both must sign the application. By submitting a financial assistance application, you give your consent for us to make necessary inquiries to confirm financial obligations and information.

8. If you have any questions, please contact the Business Office at (909) 796-6915, between the hours of 8:00am to 4:00pm Monday through Friday.

9. Submit your completed Financial Assistance Application and all required documents to :
    Totally Kids Rehabilitation Hospital
    Business Office
    1720 Mountain View Avenue
    Loma Linda, CA 92354

Failure to submit all required documentation with the application will result in an incomplete application.

We will notify you of the final determination of eligibility and appeal rights, if applicable, within 45 days of receiving a complete financial assistance application.

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Patient/Responsible Name (s):			
Address:			
Phone Number:	Home:	Cell:	Work:
Social Security Number:	Patient/Responsible Party:	Spouse of Responsible Party (if applicable):	

Family Status (List all dependents that you support)

Name	Birthdate	Relationship

Employment Status

	Employer Name	Position	Employer Contact Phone Number
Patient's Employment			
Father's Employment			
Mother's Employment			

Income: Please Provide Photocopies of Paychecks and Bank Statements and List Income

Income	Patient	Father	Mother
Gross Wages & Salary/Year before deductions	$	$	$
Self-Employment Income/Year	$	$	$
Interest & Dividends	$	$	$
Real Estate Rentals and Leases	$	$	$
Social Security	$	$	$
Alimony/Child Support	$	$	$
Worker's Comp.	$	$	$
Unemployment/Disability	$	$	$
Public Assistance	$	$	$
Retirement Income	$	$	$
All Other Sources (attach list)	$	$	$
Total Income (add lines above)	**$**	**$**	**$**

Monetary Assets	Patient	Father	Mother
Cash on hand/ Money in bank, savings, etc..			
Stocks/bonds/securities (cash value)			
Cash Value of Real Estate			

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Name_____
MR#_____
DOB_____
Physician_____

Monthly Expenses

Automobiles	Car A	Car B	Car C
Year			
Make			
Model			
Balance Owing			
Rent/Mortgage			
Other (specify)			

Unusual Expenses

Please provide information on any unusual expenses such as medical bills, bankruptcy, court judgments or settlement payments (attached list as needed).

Description	**Amount**

By signing below, I/we declare that all information provided is true and correct to the best of my/our knowledge. I/we authorize Totally Kids Rehabilitation Hospital to verify any information listed in this application. I/we expressly grant permission to contact my/our employer.

_____

Patient/Patient's Legal Representative (Print Name)

_____ _____ _____

Signature of Patient/Patient's Legal Representative Date Time

If authorized signer, Relationship to patient: _____

_____

Facility Representative Name (Print Name)

_____ _____ _____

Signature of Facility Representative Date Time