



Revised 05112026

CHARITY CARE APPLICATION

SECTION 1: PATIENT DEMOGRAPHICS

Patient's Name: _____ Social Security#: _____
FIRST LAST

Current Address: _____ Birth Date: _____
STREET ADDRESS CITY STATE Zip Code

Place of Birth: _____

Current Phone #: _____

1) Have you applied for MediCal or other government assistance in the last 6 months? YES / NO
If yes, were you awarded assistance? YES / If no, why were you denied? _____

2) Are you able to pay any portion of this bill? YES / NO If yes, how much? _____

3) Were the medical services related to an accident or third party injury? YES / NO
If yes, describe how the accident/injury occurred and the party who is responsible for covering the losses incurred resulting from the incident.

Pursuant to Federal law, I am applying for Charity Care Financial Assistance under Pomona Valley Hospital Medical Center's Charity Care Financial Assistance policy. I understand the information requested in this application is required for eligibility under the policy to be determined and assistance granted. By signing this application, I am consenting to allow the Hospital's designated staff and/or agent to verify the accuracy of the information submitted. The verification process may include but is not limited to accessing my credit report. I declare under penalty of perjury that the information I have provided is true and correct. I understand the Hospital may need information in addition to the information I am submitting today. I understand I may qualify for charity care discount based upon my income. Failure to pay the discount balance may result in assignment to an outside collection agency.

Signature: _____ Date: _____

Should you have questions regarding this application, contact:
9501.

Submit completed application and required document to:
PVHMC Eligibility Services
1798 North Garey Avenue
Pomona, CA 91767

SECTION 2: FAMILY SIZE

List all persons living in your household, their date of birth, social security# and relationship to patient.

| | NAME | DATE OF BIRTH | SOCIAL SECURITY# | RELATIONSHIP TO PATIENT |
|---|------|---------------|------------------|-------------------------|
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |
| 4 | | | | |
| 5 | | | | |
| 6 | | | | |

SECTION 3: MONTHLY INCOME

Briefly describe your employment status including date of hire and/or last date of employment/retirement. If you are receiving income from other sources, describe the type of support, the date support began and the date the support is expected to end, if applicable. Also describe any other pertinent details about your income.

Identify ALL sources of monthly income for your household. Enter the person receiving the income, the amount received each month for each income category applicable. In addition to completing this application, submit recent pay stubs and/or tax returns.

| | | NAME: | | NAME: | |
|--|--------------------|-------------|------|-------------|------|
| | | First | Last | First | Last |
| | | OCCUPATION: | | OCCUPATION: | |
| Wages | 2 recent pay stubs | | | | |
| Hourly Rate | | | | | |
| Average Monthly Hours Worked | | | | | |
| Self employment gross receipts | | | | | |
| Partnership income | | | | | |
| Social Security | | | | | |
| Supplemental Security Income (SSI) | | | | | |
| Unemployment | | | | | |
| Disability | | | | | |
| Workers Compensation | | | | | |
| General Relief | | | | | |
| Temporary Assistance for Needy Families (TANF) | | | | | |
| Food Stamps/Electronic Benefit Transfer (EBT) | | | | | |
| Alimony | | | | | |
| Child support | | | | | |
| Student Loans | | | | | |
| Pension/Annuities | | | | | |
| Interest income | | | | | |
| Dividends | | | | | |
| Capital Gains | | | | | |
| Gross Rental Income | | | | | |
| Other: | | | | | |
| TOTAL MONTHLY INCOME | | | | | |

(1) YTD P&L Statement means the current year-to-date profit & loss statement for the business/partnership

If your family does not have income, in the space below, please describe how you have been able to meet your needs for food & shelter. If another person has been providing support, in addition to the explanation below, please ask the person to send PVHMC a letter describing the type of support, frequency and duration of the support.

SECTION 4: MONTHLY EXPENSES

| | NAME: | | NAME: | |
|--------------------------------------|-------|------|-------|------|
| | First | Last | First | Last |
| Mortgage of owner occupied residence | | | | |
| Mortgage of rental property | | | | |
| Rent | | | | |
| Property Taxes | | | | |
| Car Payment | | | | |
| Childcare | | | | |
| Utilities & cell phone | | | | |
| Food & household supplies | | | | |
| Car insurance & gas | | | | |
| Clothing | | | | |
| Medical & dental expenses | | | | |
| Insurance | | | | |
| Credit Card Payments | | | | |
| Tuition | | | | |
| Child Support | | | | |
| Spousal Support | | | | |
| Installment payments | | | | |
| Laundry & leaning expenses | | | | |
| Other: | | | | |
| TOTAL MONTHLY EXPENSES | | | | |

If the reported monthly expenses exceed reported income, explain how you are able to meet these financial obligations.

SECTION 5: PROPERTY, INVESTMENTS & SAVINGS

| | Optional Documentation | NAME: | | NAME: | |
|--|------------------------|-------|------|-------|------|
| | | First | Last | First | Last |
| Value of Home (if owned) | | | | | |
| Debt on Home (if owned) | | | | | |
| Value of Vehicles (Car, motorcycle, truck, etc.) | | | | | |
| Debt on Vehicles | | | | | |
| Checking account balance | | | | | |
| Savings account balance | | | | | |
| Non-retirement investment balance | | | | | |
| Retirement investment balance | | | | | |
| Assets of business or partnership | | | | | |
| Other: | | | | | |
| TOTAL ASSETS | | | | | |

If the average monthly deposits exceed reported monthly income, explain the source of deposits and submit supporting documentation.
