

#### **CHARITY CARE APPLICATION**

### SECTION 1: PATIENT DEMOGRAPHICS

Patient's Name:				Social Security#:		
	FIRST		LAST		<u>.</u>	
Current Address:					Birth Date:	
	STREET ADDRES	CITY	STATE	Zip Code		
					Place of Birth:	
Current Phone #:						
1) Have you appl	lied for MediCal or	other governme	ent assistance in th	e last 6 month	s? YES / NO	
If yes, were you a	awarded assistance	YES / NO	lf no, why were you	ı denied?		
2) Are you able t	o pay any portion c	f this bill? YES	/ NO	If yes, how	v much?	
3) Were the med	lical services related	d to an accident	t or third party inju	ry? YES / NO		
If yes, describe he resulting from the	· •	ury occurred ar	id the party who is	responsible fo	r covering the losses incurred	
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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 failure to submit the requested documentation within 30 days of the request may result in a denial of charity care financial assistance. I understand I may qualify for charity care discount based upon my income. If I do not qualify for charity care, I further agree to pay the Hospital any portion deemed due by me within 30 days. 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:

PVHMC's Eligibility Services Department 909-865-9501.

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				





#### 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, for each type of income you identify below, submit the required documentation listed AND your most recent filed tax return including ALL supporting schedules, 2 months of bank statements, savings accounts statements, brokerage/investment statements.

		NAME:	NAME:	
		First Last	First Last	
	Required	OCCUPATION:	OCCUPATION:	
	Documentation			
Wages	2 current pay stubs			
Hourly Rate				
Average Monthly Hours Worked				
Self employment gross receipts	YTD P&L Schedule (1)			
Partnership income	YTD P&L Schedule (1)			
Social Security	Award letter			
Supplemental Security Income (SSI)	Award letter			
Unemployment	Award letter			
Disability	Award letter			
Workers Compensation	Award letter			
General Relief	Award letter			
Temporary Assistance for Needy Families (TANF)	Award letter			
Food Stamps/Electronic Benefit Transfer (EBT)	Award letter			
Alimony	Award letter			
Child support	Award letter			
Student Loans	Award letter			
Pension/Annuities	last year's 1099			
Interest income	last year's 1099			
Dividends	last year's 1099			
Capital Gains	last year's 1099			
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.



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## 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

	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.