POMONA VALLEY HOSPITAL
MEDICAL CENTER

FINANCIAL ASSISTANCE APPLICATION *Expert care with a personal touch*

SECTION 1: PATIENT DEMOGRAPHICS

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

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

Place of Birth: _____

1) Have you applied for MediCal or other government assistance in the last 6 months? YES / NO

If yes, were you awarded assistance? YES / NO 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 Financial Assistance under Pomona Valley Hospital Medical Center's 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 financial assistance. I understand I may qualify for uncompensated care or a partial discount based upon my income. If I qualify for a partial discount, 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 909.469.9441.

Submit completed application and required document to:

PVHMC Eligibility Services
1798 N. 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				

POMONA VALLEY HOSPITAL
MEDICAL CENTER

Expert care with a personal touch

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: First Last	NAME: First Last
	Required Documentation	OCCUPATION:	OCCUPATION:
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.

POMONA VALLEY HOSPITAL
MEDICAL CENTER

Expert care with a personal touch

SECTION 4: MONTHLY EXPENSES

	NAME: First Last	NAME: 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: First Last	NAME: 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.