

**Financial Assistance Application**

Henry Mayo Newhall Hospital’s Financial Assistance Program provides financial assistance to patients with medically necessary health care needs who are low-income, uninsured or underinsured, ineligible for a government program, and are otherwise unable to pay for medically necessary care based on their individual family financial situation. To determine if a patient/guarantor qualifies for financial assistance, we need to obtain certain financial information. Your cooperation will allow us to give all due consideration to your request for financial assistance.

Please complete this form and provide the most recent supporting documentation: Income tax filings (which document the patient’s income for the year in which the patient was first billed or 12 months prior to when the patient was first billed), 2 most recent bank statements, and 2 pay check stubs within a 6-month period before or after the patient is billed by the Hospital, or in the case of pre-service, when the financial assistance application is submitted.

Please submit the completed forms and supporting documentation to Patient Financial Services using enclosed envelope.

Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Account Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_ /\_\_\_ /\_\_\_ Sex\_\_\_\_ M=Male F=Female Do you own a home? Yes ( ) No ( )

Number of dependents filed on tax return: \_\_\_\_\_\_\_\_ Do you own other property? Yes ( ) No ( )

List Dependents: Do you own automobiles? Yes ( ) No ( )

Name Relationship Age

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Household Banking Information Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Balance\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Business Banking Information Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Balance\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Wages/Income Monthly Annually**

Total Household Wages\* \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\* Wages should include income from employment, self-employment, public assistance, social security, unemployment benefits, retirement/pension, alimony, child support, etc.

**Expenses Monthly Annually**

Mortgage / Rent \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Utilities \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Auto Loans \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hospital Bills \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Expenses\*\* \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*\* Include credit card payments, food, telephone, gasoline, child care expenses, etc.

My signature attests that the information I have provided on this form and the additional supporting documentation is accurate and true to the best of my knowledge.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Print Name**  **Signature Date**

Hospital Bill Complaint Program

The Hospital Bill Complaint Program is a state program, which reviews hospital decisions about whether you qualify for help paying your hospital bill. If you believe were wrongly denied financial assistance, you may file a complaint with the Hospital Bill Complaint Program. Go to HospitalBillComplaintProgram.hcai.ca.gov for more information and to file a complaint.