

Financial Assistance Program

APPENDIX B

HENRY MAYO NEWHALL HOSPITAL FINANCIAL ASSISTANCE PROGRAM APPLICATION

Patient Name	
Patient Address	
City, State, Zip	
Patient Name:	
Patient Account:	
Date of Service:	

Date:

Financial Assistance Program

Thank you for choosing Henry Mayo Newhall Hospital (HMNH) for your health care needs, where we strive to improve the health of our community through compassion and excellence in health care services. You may be eligible for financial assistance to assist you in paying health care services you will or have received at HMNH. This financial assistance applies to your hospital bill only, and does NOT apply to bills you may receive from your physicians or surgeons, although if this application is approved, some providers may extend a full or partial courtesy discount based upon the hospital acceptance determination letter.

Enclosed, please find an application for financial assistance which must be filled out in its entirety, proper documentation enclosed, signed and dated so that the review process may commence.

The application and required information are provided below. Please submit the requested documents to Patient Access Services in person or by mail to:

Henry Mayo Newhall Hospital 23845 Mc Bean Pkwy Valencia, CA 91355. Attn: Patient Financial Services

You will receive a determination of Eligibility for Financial Assistance letter within thirty days after we receive a completed application with appropriate supporting documents.

For current policy refer to Policy Management System Official copy at https://henrymayo.policytech.com (Department Owner: Administration) (Reference # 9154)





Financial Assistance Program

Completion of this application is not a quarantee of eligibility or qualification for financial assistance or any other program. Financial assistance is considered after all possible sources of potential payment (for example, health insurance, Medicare, Medicaid, liability insurance) have been exhausted. Failure to provide requested documents may result in denial of the application.

If you need any further information or assistance in completing the application, please make an appointment to come to the hospital at Patient Access Services, Main Admitting, or call 661-200-1050, Monday through Friday, 8:00 AM through 5:00 PM and a representative will assist you. For more information about the Financial Assistance Program, you may visit our website at: https://www.henrymayo.com/documents/POLICY-with-Eng-application[1].pdf

(signature line)

(printed name of financial counselor) Financial Counselor



Child Care Other

Financial Assistance Program

Financial Assistance Application

Henry Mayo Newhall Hospital's Financial Assistance Program provides financial assistance to patients with medically necessary healthcare needs with low-income, uninsured or underinsured, ineligible for a government program, and is 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. 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 () Relationship Name Age <u>Gender</u> Household Banking Information Name Balance **Business Banking Information** Name Balance Wages/Income Monthly Annual Self Wages Spouse Wages Other Family Member Wages Social Security Unemployment Benefits Retirement / Pensions Alimony / Child Support Military Family Allotments Pensions Income from Rent, Dividends, Interest Monthly **Expenses** Annual Mortgage / Rent Utilities Auto Loans Hospital Bills Telephone Food Credit Cards Gasoline

Please send the most recent following supporting documentation: Income Tax Filings or W-2s, 3 Bank Statements, 4 Pay Check Stubs, and proof of expenses.

My signature attests that the information I have provided on this form is accurate and true to the best of \underline{my} knowledge.

Print Name Signature Date

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