MONROVIA MEMORIAL HOSPITAL

# Financial Needs Assessment Form

**Return completed form to:** CEO, Monrovia Memorial Hospital, 323 S. Heliotrope Ave, Monrovia, CA 91016

**STEP 1: COMPLETE ALL INFORMATION**

| | |
|---|---|
| Patient's Name: | Birth Date: |
| Address: | City, State, Zip: |

**STEP 2: REPORT HOUSEHOLD MEMBERS, INCOME AND ASSET INFORMATON: Provide proof of income. The most recent Federal Income Tax forms, including Schedule C if you are self-employed, pay stubs, copy of Government checks. Include wages, pension, disability, social security, unemployment, alimony and any other sources of income.**

| Family Members: Self & immediate family | Date of Birth | Relation to Patient | Gross Monthly Income (pre-tax) | Employers Name | Employers Phone |
|---|---|---|---|---|---|
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**LIST ALL: Provide the most recent Bank/Credit Union Statements.**

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|---|---|---|
| Checking/Credit Union Acct: | Bank/Credit Union Name: | Balance: |
| Savings/Share Acct: | Bank/Credit Union Name: | Balance: |
| Cash, Stocks, Bonds, IRA, 401K, CDs, Trust Acct: | Bank/Credit Union Name: | Balance: |

**Are you buying or do you own Real Estate (house, land, lot) or any part interest in real estate? Provide proof of value (tax ticket) and mortgage balance (letter from lien holder or mortgage statement)**

| | | |
|---|---|---|
| Real Estate Address: | Taxable Value: | Mortgage Balance: |
| Real Estate Address: | Taxable Value: | Mortgage Balance: |

**STEP 3: FINANCIAL OBLIGATIONS per MONTH:**

| | |
|---|---|
| Mortgage/Rent: | Utilities: |
| Auto Loans: | Credit Cards: |
| Other (Food, Fuel, Alimony, Child Support, etc: | |

I understand that the information provided in this application will be used to evaluate my ability to pay my medical bills. I agree to cooperate with Monrovia Memorial Hospital (Hospital) in pursuing reimbursement from any available insurance or medical payment programs. I understand that all or part of my indebtedness to Hospital may be reduced if I qualify under the current Financial Needs policy. I certify that the information contained in this form is accurate, and I authorize any and all parties to release any information necessary to confirm this information. I further authorize the Hospital to obtain credit reports with respect to me. I reaffirm that I am financially responsible for the accounts upon which I have applied for assistance.

_____ _____ _____

Print Name Signature Date