PACIFICA HOSPITAL OF THE VALLEY
CHARITY ELIGIBILITY PROGRAM

Revised 8/2004

Financial Assistance Application

Patient Information

Patient Name | Patient Account Number

Patient Street Address, City, State, and Zip

Telephone Number | Social Security Number | Birth Date (Month/Date/Year)

Employed | Employer (Name, Address, &Telephone Number) | Unemployed

Position/Title | Monthly Income-Gross

Spouse Information

Spouse Name | Social Security Number | Birth Date (Month/Date/Year)

Spouse Employer (Name, Address, &Telephone Number)

Position/Title | Monthly Income-Gross

Dependent Information

Total Number of Persons in Household _____ Do any Other Persons Contribute? _____ If yes, Amount _____

Income Verifications: Please provide any of the following types of documentation to verify your income.

• IRS Form W-2 • Paycheck Remittance • Tax Return • Bank Statements • Employer Verification	• Proof of Participation in Governmental Assistance Programs such as food stamps, CDIC, Medicaid, or AFDC • Social Security, Workers Compensation, or Unemployment Compensation determination letters • Other, Please Describe

If you are unable to provide one of the sources of income documentation listed above, please explain why this information is not available:

Other Resources: Please provide the total amount of other resources available to you, including such things as savings accounts, checking accounts, stocks, bonds, etc. $ _____

I understand Pacifica Hospital of the Valley may verify the financial information contained in this Financial Assistance Application in connection with PHOV's evaluation of this application, and by my signature hereby authorize my employer to certify the information provided in the application. I also authorize PHOV to request reports from credit reporting agencies and the Social Security Administration. I am aware that falsification of information on this application may result in denial of financial assistance. I understand I must retain copies of all documents for my future reference.

Signature of Patient or Responsible Party | Date

Hospital Employee Signature | Date