Victor Valley Global Medical Center

FINANCIAL ASSISTANCE APPLICATION

INSTRUCTIONS

1. Please complete all areas on the attached application form. If any area does not apply to you, write N/A in the space provided.
2. Attach an additional page if you need more space to answer any questions.
3. You must provide proof of income when you submit this application. The following documents are accepted as proof of income:
   - If you filed a Federal Income Tax Return, you must submit a copy of:
     - Federal Income Tax Return (Form 1040) from the most recent year. You must include all schedules and attachments as submitted to the Internal Revenue Service.
   - If you did not file a Federal Income Tax Return, please provide both of the following:
     - Two (2) most recent paycheck stubs
     - A letter explaining why you do not file a Federal Income Tax Return
   - If you have no income, please provide a letter explaining how you support yourself/family.
4. Your application cannot be processed until all required information is provided.
5. It is important that you complete and submit the financial assistance application along with all required attachments within fourteen (14) days.
6. You must sign and date the application. If the patient/guarantor and spouse provide information, both must sign the application.
7. If you have questions, please call the Patient Financial Services Department at (760) 245-8691, extension 4116, for assistance.
8. Send your completed application to:

   Victor Valley Global Medical Center
   Patient Financial Services
   15248 Eleventh Street
   Victorville, CA 92395

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15248 ELEVENTH STREET • VICTORVILLE, CA 92392
TELEPHONE: (760) 245-8691 • FAX: (760) 955-2924

Patient/Guarantor Name: _____

Spouse's Name: _____

Address: _____

_____

Home Phone: _____ Work Phone: _____

Patient's Social Security Number: _____

Patient's Date of Birth: _____

Spouse's Social Security Number: _____

Spouse's Date of Birth: _____

FAMILY STATUS
[List all dependents that you support (attach an additional sheet if needed)]

Name: _____ Age: _____ Relationship: _____

Name: _____ Age: _____ Relationship: _____

Name: _____ Age: _____ Relationship: _____

Name: _____ Age: _____ Relationship: _____

Name: _____ Age: _____ Relationship: _____

Name: _____ Age: _____ Relationship: _____

EMPLOYMENT STATUS

Patient/Guarantor Employer: _____

Position: _____

Contact Person: _____ Phone Number: _____

Spouse's Employer: _____

Position: _____

Contact Person: _____ Phone Number: _____

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INCOME
[Gross Wages (Monthly)]

Patient: $ _____ Guarantor: $ _____

Self-Employment Income: $ _____ Interest & Dividends: $ _____

Real Estate Rentals & Leases: $ _____

Social Security:	Patient: $ _____	Spouse: $ _____
Alimony:	Patient: $ _____	Spouse: $ _____
Child Support:	Patient: $ _____	Spouse: $ _____
Unemployment/Disability:	Patient: $ _____	Spouse: $ _____
Public Assistance:	Patient: $ _____	Spouse: $ _____
All Other Sources (attach list):	Patient: $ _____	Spouse: $ _____

UNUSUAL EXPENSES
[Please provide information on any unusual expenses, such as medical bills, bankruptcy, court judgments or settlement payments (attach an additional sheet if needed)]

Description: _____ Amount: $ _____

Description: _____ Amount: $ _____

Description: _____ Amount: $ _____

By signing below, I/we declare that all information provided is true and correct to the best of my/our knowledge. I/we authorize Victor Valley Global Medical Center to verify any information listed in this application. We expressly grant permission to contact my/our employer, banking and lending institutions, and to check my/our credit history.

_____ _____
Signature of Patient/Guarantor Date

_____ _____
Signature of Spouse Date