ATTACHMENT C

APPLICATION/FINANCIAL STATEMENT

BIGGS GRIDLEY MEMORIAL HOSPITAL dba ORCHARD HOSPITAL
240 SPRUCE STREET – GRIDLEY, CA 95946

APPLICATION/FINANCIAL STATEMENT

APPLICANT'S NAME:_____ **SPOUSE NAME:** _____

ADDRESS:_____ **PHONE:**_____

ACCOUNT #:_____ **SSN:** _____ _____
(APPLICANT) **(SPOUSE)**

FAMILY STATUS (List all dependents that you support)

NAME	RELATIONSHIP	AGE	SEX
_____	_____	_____	☐ Male ☐ Female
_____	_____	_____	☐ Male ☐ Female
_____	_____	_____	☐ Male ☐ Female
_____	_____	_____	☐ Male ☐ Female
_____	_____	_____	☐ Male ☐ Female

FAMILY SIZE

Total Family Members (add applicant, spouse and dependents from above):_____

EMPLOYMENT AND OCCUPATION

APPLICANT'S EMPLOYER:_____ POSITION:_____

CONTACT PERSON & TELEPHONE: _____

IF SELF EMPLOYED, NAME OF BUSINESS:_____

SPOUSE'S EMPLOYER:_____ POSITION:_____

CONTACT PERSON & TELEPHONE: _____

IF SELF EMPLOYED, NAME OF BUSINESS:_____

CURRENT INCOME (Select One): Weekly_____ Bi-Weekly_____ Monthly ____ Yearly_____ Other____

CATEGORY	APPLICANT	SPOUSE	OTHER FAMILY MEMBER
Gross Pay (before deductions):	$_____	$_____	$_____
Farm or self-employment:	$_____	$_____	$_____
Public Assistance:	$_____	$_____	$_____
Social Security:	$_____	$_____	$_____
Unemployment Compensation:	$_____	$_____	$_____
Workman's Compensation:	$_____	$_____	$_____
Strike Benefits:	$_____	$_____	$_____
Alimony:	$_____	$_____	$_____
Child Support:	$_____	$_____	$_____
Military Family Allotments:	$_____	$_____	$_____
Pensions:	$_____	$_____	$_____
Income from Dividends and Interest:	$_____	$_____	$_____
Income from Rent, Real Estate or Property:	$_____	$_____	$_____
TOTAL:	**$_____**	**$_____**	**$_____**

COMPLETE SECTION _____ (Orchard Hospital representative to place X in appropriate box)

☐ **A. COMMUNITY CARE FINANCIAL ASSISTANCE MONETARY ASSETS (must include assets for applicant, spouse and other family member listed on page 1 of 3)**

ASSETS

Cash on Hand: $_____
Checking Account Balance: $_____
Savings Account Balance $_____
Credit Union Account Balance: $_____
Trust Accounts: $_____
Additional Income: $_____

TOTAL MONETARY ASSETS: $_____

In order for us to consider your request, you must include one of the following items:

1. Verification of income. (Note: Normally income consideration will be based on, but not limited to, the average of the previous three (3) months. Sometimes, however, in certain cases, e.g. self-employment, it may be appropriate to use an averaging of the previous 12 months' income. Orchard Hospital reserves the right to determine the most fair and appropriate application of this policy.)

2. Last years' tax returns

☐ **B. HIGH MEDICAL COMMUNITY CARE (LIABILITY AFTER INSURANCE {EXCLUDES HMO AND PPO}) – MONETARY ASSETS AND LIABILITIES (must include monetary assets and liabilities for applicant, spouse and other family member listed on page 1 of 3)**

ASSETS		MONTHLY LIABILITIES	
Cash on Hand:	$_____	Real-Estate Payments:	$_____
Checking Account Balance:	$_____	Rental Payment (Home or Apartment):	$_____
Savings Account Balance	$_____	Ins. Premiums (Auto, Home, Medical):	$_____
Credit Union Account Balance:	$_____	Avg. Annual Taxes:	$_____
Property Owned Value:	$_____	Avg. Monthly Utilities:	$_____
Home Value (if owned):	$_____	Other Liabilities (provide descriptions):	
Trust Accounts:	$_____	_____	$_____
Additional Income:	$_____	_____	$_____
Automobile(s) Estimated Value:	$_____	_____	$_____
Make & Model:	_____	_____	$_____
Make & Model:	_____	_____	$_____
Make & Model:	_____	_____	$_____
TOTAL MONETARY ASSETS:	**$_____**	**TOTAL LIABILITIES:**	**$_____**

MEDICAL EXPENSES INCURRED AND PAID

Total patient's out-of-pocket costs incurred at this hospital in prior 12 months (net of any discounts or write- offs): $_____

Total patient and patient's family out-of-pocket medical expenses (including but not limited to, hospital services, physician services, drugs, and all other medical services) paid by the patient or patient's family in prior 12 months: $_____

In order for us to consider your request, you must include the following items:

1. Verification of income. (Note: Normally income consideration will be based on, but not limited to, the average of the previous three (3) months. Sometimes, however, in certain cases, e.g. self-employment, it may be appropriate to use an averaging of the previous 12 months' income. O r c h a r d H o s p i t a l reserves the right to determine the most fair and appropriate application of this policy.)
2. Last years' tax returns
3. Checking and/or savings accounts statements for the past two months
4. Copies of rental or mortgage payment (1 month)
5. Copies of utilities bills (1 month)
6. Copy of auto loan payments (1 month)
7. Copies of other outstanding liabilities

By signing this completed Financial Statement Condition form, I hereby declare the foregoing to be true under penalty of perjury under the laws of the state of California. I also agree to allow Orchard Hospital to check employment and credit history for the purpose of determining my eligibility for a financial discount.

_____ _____

(Applicant's signature) (Date)

_____ _____

(Spouse's signature) (Date)