Verity Health

ATTACHMENT D

FINANCIAL ASSISTANCE APPLICATION

Documents used for verification of a patient's financial resources and household income in the Financial Assistance Application may include, but are not limited to:

- Copies of current paystubs, Social Security, disability or unemployment checks and award letters;
- A copy of any Medi-Cal Decision/Denial Notice;
- Household income of the patient and, if the patient is 18 years or older, the patient's spouse or domestic partner, and any dependent children under age 21, whether living at home or not; if the patient is under age 18, consider income of the patient, the patient's parents, guardians or caretaker relatives, and other children under age 21, whether living at home or not.

Please return your completed application, with all requested forms, to the following address or drop off at your local Verity Health HBRC Office.

Verity Health System
Attention: HBRC
1900 Sullivan Avenue
Daly City, CA 94015

Please be advised this is not a guarantee that financial assistance will be awarded, and your payments should continue a regular basis until a determination has been made. Your application and the information provided will be reviewed. A decision will be provided to you in writing.

Thank you for your cooperation. We look forward to assisting you through this process. Should you have any questions about your application, please contact our Financial Assistance Team in the Health Benefits Resource Center (HBRC) at 888-874-2585.

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CHARITY CARE AND FINANCIAL ASSISTANCE APPLICATION

LAST NAME (PATIENT)	FIRST	MIDDLE	SOCIAL SECURITY #	BIRTHDATE

RESIDENCE ADDRESS (FACILITY ADDRESS IF HOMELESS)	HOW LONG	PHONE

CITY	STATE	ZIP	MARITAL STATUS

LAST NAME (GUARANTOR IF DIFFERENT FROM ABOVE)	SOCIAL SECURITY #	BIRTHDATE
EMPLOYER OF GUARANTOR (NAME AND FULL ADDRESS)		
PHONE		MONTHLY GROSS PAY
OTHER EMPLOYER (NAME AND FULL ADDRESS)		
PHONE		MONTHLY GROSS PAY
IF UNEMPLOYED, NAME OF LAST EMPLOYER AND FULL ADDRESS		
		LAST EMPLOYMENT DATE

DEPENDENT FAMILY MEMBERS (IF MORE SPACE IS NEEDED, PLEASE ATTACH AN ADDITIONAL SHEET OF PAPER)	BIRTHDATE	RELATIONSHIP	EMPLOYER	ANNUAL INCOME
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				

Verity Health

□ RENT HOME □ OWN HOME			*OTHER MONTHLY INCOME* $ *SPECIFY SOURCE*	
OWED TO OTHERS TO WHOM OWED	PRESENT BALANCE	MONTHLY PAYMENT	BANK NAME & ACCOUNT NUMBER	ACCOUNT BALANCE
RENT/MORTGAGE			CHECKING	
UTILITIES			SAVINGS OR CERTIFICATE	
FOOD			403(B) OR 401(K)	
AUTO LOAN			STOCKS & BONDS	
CREDIT CARDS (PLEASE LIST BELOW)			IRA	
OTHER OBLIGATIONS (CHILD SUPPORT, ALIMONY, INSURANCE PAYMENTS)			AUTO (YEAR & MAKE)	
ADDITIONAL INFORMATION			AUTO (YEAR & MAKE)	
BILLS OWED TO OTHER MEDICAL PROVIDERS			OTHER ASSETS (ADDITIONAL ASSETS NOT INCLUDED)	
COST OF PRESCRIPTION MEDICATION(S)			RESIDENCE MARKET VALUE	
			INSURANCE CASH VALUE	
			OTHER ASSETS (DESCRIBE; I.E. SECOND HOME)	
			TRUSTEE NAME & ACCT. NUMBER	
TOTAL DEBTS			**TOTAL ASSETS**	

I CERTIFY THAT ALL STATEMENTS MADE IN THIS APPLICATION ARE TRUE AND COMPLETE. YOU ARE HEREBY AUTHORIZED TO CHECK MY CREDIT HISTORY IN ORDER TO EVALUATE THIS APPLICATION FOR FINANCIAL ASSISTANCE CONSIDERATION.

SIGNATURE	DATE