FINANCIAL ASSISTANCE APPLICATION

PATIENT NAME ____ APPLICATION DATE_____________________

ACCOUNT NUMBER(S) _________________________________ ________ DATE OF SERVICE_______________________

GUARANTOR NAME ____

GUARANTOR ADDRESS____ _____

GUARANTOR PHONE NUMBER ________________________________ SSN GUARANTOR_____________________________

SSN PATIENT______________________________________ SPOUSE _____________________________________

IS PATIENT COVERED BY INSURANCE? ______ MEDICARE _______ MEDI-CAL ________OTHER _______________________

FAMILY SIZE: Number of Adults (including yourself)_______________Number of Children (Under 18)_______________________

EMPLOYMENT AND OCCUPATION:
EMPLOYER ______________________________ POSITION _________________________________
CONTACT PERSON & PHONE NUMBER: ____

CURRENT MONTHLY INCOME:

	Guarantor	Family Members
Gross Pay (before deductions)		
Income from Business		
Other Income:		
Interest & Dividends		
From real estate / property		
Social Security		
Other (specify)		
Alimony, support payments made		

Total Estimated Annual Income __________________ ________ __________________________

I agree to allow Verdugo Hills Hospital to check employment history and verify information provided above for the purpose of determining my eligibility for

additional financial discounts. I understand that I am required to provide the last two months of pay stubs and copies of Federal 1040 or 540 tax returns for the most recent income tax year of all working family members claimed on this form.

(Signature of patient or guarantor)	(Signature of spouse)

FORM: PFSOM 1004 – 002 1/08