Community Memorial Health System

Where Excellence Begins with Caring

Community Memorial Health System
5855 Olivas Park Dr.
Ventura, CA 93003

To apply in person:
5855 Olivas Park Dr
Ventura, Ca 93003

REGUEST FOR FINANCIAL ASSISTANCE
UNCOMPENSATED CHARITY CARE
APPLICATION

Patient Name_____

Patient Account Number(s)_____

Guarantor Name_____

Date of Birth:_____**SS#**_____-_____-_____

Phone ( )_____

Address_____

City, State, Zip_____

Spouse Name_____**SS#**_____-_____-_____

Are you a U.S. Citizen? ____**Yes** ___**No**

If not, a resident alien ? ____**Yes** ___**No**

If not, non-resident alien? ____**Yes** ___**No**

<u>FAMILY STATUS</u>: List all dependents who you support

Name	**Age**	**Relationship**
_____	_____	_____
_____	_____	_____

_____ _____ _____

_____ _____ _____

_____ _____ _____

EMPLOYMENT AND OCCUPATION:

Employer_____Position:_____
_____

If self employed, name of business_____

Employer
Address_____

Phone Number_____How long employed_____

Spouse
Employer:_____Position:_____

If self employed, name of
business_____

Statement of Current Income and Expenditures

Current Monthly Income:	**Patient**	**Spouse**
Gross Pay	**$_____**	**$_____**
Income from business (if self employed)	**$_____**	**$_____**
Interest and dividends	**$_____**	**$_____**
Income from real estate or personal property	**$_____**	**$_____**
Social Security/Retirement Income	**$_____**	**$_____**
Alimony, support payments	**$_____**	**$_____**
Unemployment compensation	**$_____**	**$_____**
Other Income	**$_____**	**$_____**

Total Monthly Income	**$_____**	**$_____**

Current Monthly Expenses:

Rent or House Payment	**$_____**	**$_____**
Real Estate Taxes	**$_____**	**$_____**
Utilities	**$_____**	**$_____**
Alimony, support payments	**$_____**	
$_____		
Education	**$_____**	**$_____**
Food	**$_____**	**$_____**
Payroll Deductions	**$_____**	**$_____**
Medical, dental and medicines	**$_____**	**$_____**
Other_____	**$_____**	**$_____**
Total Monthly Expenses	**$_____**	**$_____**
Net Monthly Income after Expenses	**$_____**	**$_____**

By signing this Application, I agree to allow Community Memorial Health System to contact my employer, bank and other sources, as well as request a credit history for the purpose of determining my Charity Care eligibility. I understand that I do not qualify for services under the Charity Care guidelines that I will be personally liable for the charges of the services rendered. I attest that the information provided on this application is true and accurate. If it is determined that any information provided here is false or misleading, I understand that eligibility for Charity Care will be denied.

I also understand that this application is for Community Memorial Health Systems charges only. All physicians, radiology professional, Ojai emergency room professional, ambulance, anesthesiology services or pathology services are billed separately from Community Memorial Health Systems are not covered by this application.

_____ _____

(Signature of Patient or Guarantor) **(Date)**

_____ _____

(Signature of Co-Applicant) **(Date)**

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5855 Olivas Park Dr.
Ventura, CA 93003
Business Hours
Mon. – Fri. 8:00 am – 4:00 pm

REQUEST FOR FINANCIAL ASSISTANCE
UNCOMPENSATED CHARITY CARE APPLICATION INSTRUCTIONS

Date: _____

Patient Name: _____

Account Number(s): _____

Total Balance for Consideration: $_____

In response to your request for financial assistance regarding the above identified account number(s), please submit the following documentation, no later than ten (10) days of the date of this letter.

It is important that the application be complete, and all requested information is provided in order to properly assess your ability to pay all or part of the hospital bill.

(1) Fully completed charity application (enclosed with this letter)

(2) Copies of your current period payroll check stubs for the last three months. Note that this also includes public assistance (for example, Social Security, Unemployment, or Disability). If you receive your income in cash, please provide us with a written statement from your employer stating your income.

If you currently are not receiving any income please write a brief paragraph on a separate sheet of paper stating your current financial situation. Be sure to include the date and signature. If you are receiving financial assistance or living with

someone, please have him or her write a statement explaining the situation.

(3) Rent or mortgage verification.

(4) Copy of your prior month's bank statement (savings, checking, IRAs, money market accounts, etc…)

(5) Copy of your prior year's tax return (the completed and signed 1040)

Please send copies of these documents because they will not be returned to you.

If you have any questions, please telephone me directly at (805)_____

for assistance.

_____

Patient Account Representative
Community Memorial Health System