Memorial Hospital
of Gardena
1145 West Redondo Beach Boulevard, Gardena, California 90247 ■ (310) 532-4200

Date:

[Patient Name]
[Patient Address]
[Patient City, State Zip]

Re: Application for financial assistance, Account #

Memorial Hospital of Gardena has a special program that could possibly assist you with your hospital bill. Currently, our records indicate that you have no medical insurance coverage to pay your outstanding balance with the hospital. If this is incorrect please contact us immediately to provide this information.

Your current hospital bill totals $. Unless you qualify for assistance, this balance is your responsibility to pay immediately.

Attached is a financial assessment form that you must complete so that we can determine your ability to pay for the services provided by Memorial Hospital of Gardena. The hospital does provide charitable assistance in the event that we are able to determine that you are unable to pay for the services. Please complete the attached form fully and return it to the hospital at the address shown on this letter. Additionally, we must have legible copies of the documents listed on this letter below returned with your application. YOUR IMMEDIATE RESPONSE IS REQUIRED.

To avoid any further collection process on your outstanding balance we must receive your response within 30 days. Please return the following information:

1. Completed application
2. Signed authorization
3. IRS tax returns with W-2 form for the last two years
4. Copies of last two pay stubs
5. Means of support letter
6. Copies of last two bank statements
7. Copy of Medi-cal/SSI denial letter (if applicable)
8. Proof of Income from SSA (if applicable)
9. Proof of Income from Disability (if applicable)

Once received, your application will be reviewed and you will receive notification from us of the acceptance or rejection of your financial assistance application.

If you need further assistance you may contact the hospital's Business Office at 310-512-6169.

Sincerely,

Business Office

Patient Name	Facility: DOS:
Patient Number	Confidential Financial Statement (Application)

RESPONSIBLE PARTY

Name		Marital Status	Social Security Number
Street Address, City, State, Zip		How long at this address	Home Phone
Employers Name and Address (If Unemployed –How Long)			Business Phone
Position / Title	Monthly income – Gross	Monthly income - Net	Length of current employment

SPOUSE

Name			Social Security Number
Employer Name and Address			Business Phone
Position / Title	Monthly income – Gross	Monthly income – Net	Length of current employment

DEPENDENTS

Name & Year of Birth of all dependents in household	Total Number of Dependents in household	Do Any Other Persons Contribute? If Yes, Amount: Yes/No Amount

INCOME PER MONTH & ASSETS

Dividends, Interest	$	Child Support / Alimony	$
Public Assistance / Food Stamps	$	Rental Income	$
Social Security	$	Grants	$
Unemployment Compensation	$	IRA	$
Workers' Compensation	$	Other	$
Savings	$		

EXPENSES PER MONTH

Mortgage / Rent Payment:	$ Balance: $	Medical / Dental	$
Own Home? (Yes/No)		Doctor – Name	$
Food	$	Doctor – Name	$
Utilities:	$	Doctor – Name	$
Electric	$	Credit Cards:	$
Gas	$	Visa Limit	$
Water / Sewer	$	Mastercard Limit	$
Trash	$	Discover Limit	$
Phone	$	Other Limit	$
Cable	$	Installment Loans	$
Auto Payments	$	Child Support	$
Auto Expenses	$	Miscellaneous Expenses	$
Insurance:			
Auto Premium	$		
Life Insurance	$		
Health Insurance	$		

OFFICE USE ONLY
Gross income
Net income
Total Expenses
Total Net income (loss)

To my knowledge the information provided above is true. I authorize a Credit Bureau Report to be secured by the Hospital or its agent to verify my financial standing.

PATIENT/GUARANTOR SIGNATURE DATE