PALMDALE REGIONAL MEDICAL CENTER

Date:

Name:
Pt Name:
Address:

Please find enclosed an application for financial assistance which shall be supported by income tax returns or **proof of income for all wage earners within the household** . If the patient can demonstrate that tax returns do not exist or are unavailable, the hospital may accept pay check stubs as an alternate form of income verification. The application and all required documents must be supplied to the hospital within 90 days of discharge and or service date. **"Please do not send original documents, copies only".**

Failure to provide these documents may result in your application for financial assistance being denied.

Should you have any questions regarding the application, please call the Business Office at 866-597-1776.

Respectfully,

Customer Service
UHS Pacific Region CBO
(866) 597-1776

PALMDALE REGIONAL MEDICAL CENTER

Account Number: _____

Patient Name:

_____

Address:

_____

City:

_____State:_____Zip:_____

_

Phone: _____ Social Security:

_____

Date of Birth: _____ Place of Birth:

_____

Mother's Maiden Name: _____

Employer's Name: _____

Address: _____

Phone: _____ Job Title:

_____

Yearly Income: _____ Monthly Income:

_____

List persons in the household: _____ Age:

_____

_____ Age:

_____

_____ Age:

_____

Do you Support household members? Yes/No_____ Do you own/rent? _____

Amount of rent/mortgage: _____ Name of Bank: _____

Checking or Savings account number: _____

Are you eligible or do you receive any of the following: (list amount)

Medi-Cal	$	Work Comp	$
Pension	$	Disability	$
Unemployment	$	AFDC	$

Child Support	$	OASDIS	$
Medicare	$	Alimony	$
Railroad	$	Other	$

I certify that the information I have provided is true and accurate to the best of my knowledge. I understand that the information that I submit is subject to verification, including credit agency scoring, and subject to review by federal and/or state agencies and others as required. I authorize my employer to release Palmdale Regional Medical Center proof of my income. I understand that if any information I have given proves to be untrue, Palmdale Regional Medical Center will re-evaluate my financial status and take whatever action becomes appropriate.

_____

_____

Signature of Guarantor/Patient Date