



## LODI HEALTH FINANCIAL ASSISTANCE APPLICATION

Lodi Health is committed to providing financial assistance to patients who cannot afford to pay for medical services. If you feel you may be eligible for financial assistance, please fill out the following application and attach copies of:

➤Tax Returns ( Previous 2 years)

➤ Pay Stubs (Most recent 3 months)

➤ Social Security Benefits

➤ Bank Statements ( Most recent 3 months for all bank accounts)

➤W-2 or UnemploymentSstatement

➤ Proof of Insurance denial coverage

7 W Z or Oriemploymentosi	latement		> 1 1001 01 III3	dianice defilal coverage	C			
I have a lawsuit, settlement, personal injury, or liability claim pending.						□Yes □No		
Reason:								
have the availability of insurance through my employer or my spouses's employer.								
Reason:								
Responsible Party / Patie	nt							
Name	nt .			Social Security Number		Birthdate (Month/DD/YYYY)		
Address								
City			State		ZIP Code			
· 								
Phone(s)			(Patient/Spouse	and Dependents) Marital Status		Are you claimes on another tax return?		
Home	Cell					□Yes □ No		
Student	□ Dort Time Student	School						
□Full-Time Student Employment Status	☐ Part Time Student		Employer Name					
	ne □ Self Employed □ Ur	nemployed	Linployor Hame					
Employer Addrtess	, ,				Employer Phon	е		
City				State		ZIP Code		
City				State		ZIF Code		
Job Title				Employment Length	Unemployment	Date/Length Month/DD/YYYY		
Spouse/Partner								
Name				Social Security Number		Birthdate (Month/DD/YYYY)		
Address								
City				State		ZIP Code		
Phone(s)		Household Size	e (Patient/Spouse	and Dependents)	Marital Status	Are you claimes on another tax return?		
Home		1.1040011014 0120	/ (	and Dopondonio,	mama: Grando			
Cell						□Yes □ No		
Student	Student School							
□Full-Time Student	☐ Part Time Student		Employer Nom					
Employment Status			Employer Name	<b>3</b>				
□Full Time □ Part Tim	ne □ Self Employed □ Ur	nemployed						
Employer Addrtess					Employer Phon	e		
O.:				T <sub>a</sub> .		Ino out		
City				State		ZIP Code		
Job Title				Employment Length	Unemployment	Date/Length Month/DD/YYYY		
DEPENDENTS								
Full Name				Relationship		Birth Date (Month/DD/YYYY)		
			<u> </u>					
			<del> </del>					
				+				
				·†				

Bank Account Balances				Account Type			1	
						,,,,	Invest	
				ments /				
						Securi		
Deal Mana			Addroop		Chapting (.()	Covings (.()	ties	Assount Rolance
Bank Name		Address		Checking (✓)	Savings (✓)	( <b>√</b> )	Account Balance	
Property (Inclu	de all prope	erty and assets that you o	own, including all recreation	nal vehi	cles.etc.)			
Туре	Detail	,	,	Estimate				Unpaid Balance
Residence							·	
Vehicles	(Type/Year/N	Make)						
Vehicles	(Type/Year/N							
Vehicles	(Type/Year/N	Make)	lake)					
Land								
Rental Property	-			}				
Business Other								
Household Inc				I.				I
	Income Description Source						Monthly Income Amount	
Responsible Party/Patient								
Interest/Dividends	Spouse/Partner							
Interest/Dividends Stocks/Bonds								
Pension								
Rental/Property								
Disability Disability								
Alimony/Child Support								
Other								
Insurance (Indi	icate all type	es of insurance policies v	vou currently hold, e.g., hea	alth.life.a	auto.etc.)			
Туре	71	es of insurance policies you currently hold, e.g., health,life,auto,etc.)  Company Name						Monthly Payment
Health		Company Hame						
Health								
Auto								
Auto								
Life	Life							
Life								
	Home Owners/Renters							
Home Owners/Renters Other								
Other								
		te your average monthly	household expenses, e.g.,g	rocerie	s,utilities,mea	lications,etc.)		T
Expense Description							Average Monthly Expense	
Mortgage/Rent								
Groceries								
Utilities Auto (gas/repairs)								
Auto (gas/repairs) Phone								
Mobile Phone								
Cable/Internet								
Entertainment								
Clothing								
Child Support								
Alimony								
Medications								
Other								

Creditors (Indicate all other	r payments, e.g.	, bank payments, credit cards, ot	her medical,etc.)				
Туре	Company Name			Unpaid Balance	Monthly Payment		
Mortgage							
Home Equity							
Personal Loan							
School Loan							
Vehicle Loan							
Vehicle Loan							
Credit Card							
Credit Card							
Credit Card							
Credit Card							
Credit Card							
Medical: Doctor							
Medical: Doctor							
Medical:Hospital							
Medical:Hospital							
Other							
Other							
assistance request. I hereby gra	nt permission to Lo	di Health and it's affiliates and representa	tives or agents to investigate	the information contain	ed herein, and to obtain credit		
Patient/Responsible Party Signature				Date (Month/DD/YYYY)			
Lodi Health Representative Signa	ature	Date (Month/DD/YYYY)					
For Internal Use only							
Date Interviewed	Date Issued Approval Period (Month/DD/YYY to Month/DD/YYYY)						
Comments:							