Dignity Health
Dominican Hospital

Financial Assistance Application

Patient Account Number(s)

Patient Last Name | Patient First Name | Patient Social Security # | Patient Date of Birth

Guarantor Last Name (If Different) | First Name | Guarantor Social Security # | Date of Birth

Guarantor Home Address | Home Telephone Number

City | State | Zip Code

Guarantor's Employer Name | Guarantor Job Function/Department

Guarantor's Employer Address | Guarantor's Employer Telephone

City | State | Zip Code

Spouse's Employer Name | Spouse's Job Function/Department

Spouse's Employer Address | Spouse's Employer Telephone

City | State | Zip Code

People in household (including applicant)

Name	Relationship to Patient	Date of Birth	Employer	Annual Income
1)				
2)				
3)				
4)				
5)				
6)				
7)				
8)				
9)				
10)				

Dignity Health Payment Assistance Application (Continued)

In order to determine who truly qualifies for financial assistance, we must first require submission of the information listed below to demonstrate financial hardship. Please complete the application and return it with all the following items listed below. If you are unable to supply one of the documents or there are additional factors that may influence the evaluation, please submit a written statement explaining your situation.

Documentation Required:

1. Proof of Identity - **One** of the following:
   - Copy of Social Security Card
   - Copy of state issued driver's license
   - Copy of other photo ID

2. Verification of Current Address - **One** of the following:
   - Rent receipt
   - Utility Bill

3. Denial of eligibility from Medi-Cal or Medicaid program from state of residence.

4. Three (3) months current pay stubs or the most current Income Tax Return for all family* members. If self-employed, include Schedule C with your Tax Return. If these are unavailable, please write an explanation on a separate piece of paper, stating your financial situation over the last three months, and submit it with this application.

*A Patient's Family includes:

a) For persons 18 years of age and older, a spouse, domestic partner, as defined in Section 297 of the Family Code, and dependent children under 21 years of age, whether living at home or not.
b) For persons under 18 years of age, a parent, caretaker relatives, and other children under 21 years of age of the parent or caretaker relative.

Once we have completed our initial review of the documents provided, the following may be required to determine qualification:

Proof of Monetary Assets - **All** of the following:

- Checking account statements-last 3 months
- Savings account statements-last 3 months
- Stocks, Bonds, & CD's

By signing below you agree to be considered for Payment Assistance. Additionally, you certify that all the statements made on this application are true and complete to the best of your knowledge. Should it be determined that the information you provided is incomplete or false, any discount on your bill may be reversed and payment in full may be expected from you. By signing below, you authorize Dignity Health to check references and credit history in order to evaluate this application for financial assistance consideration.

If you receive payment from an insurance company, workers compensation plan, or any other third party, you agree to inform the hospital of any such payment. The hospital retains its right to collect the original, full billed charges should a third party provide you with payment for the hospital's services.

_____ _____

Signature of person responsible for bill (Guarantor) Date

Mail completed application to:

Dominican Hospital
1555 Soquel Drive
Santa Cruz, CA 95065

Revised January 1, 2016