JOHN MUIR HEALTH

HELP PROGRAM: PATIENT ASSISTANCE APPLICATION

The Patient Assistance Program is a self-funded program of John Muir Health. The purpose of the program is to offer financial assistance for medical bills incurred at our facilities only. It will not cover any amounts owed to any physicians or other providers who are not employees of the Medical Centers.
All requested documents must be submitted in order for the application to be complete, and to be considered for approval.

PLEASE PRINT ALL RESPONSES:

PATIENT NAME: _____ _____
(First Name) (Last Name)

Address: _____ _____
(Street Number and Street Name). (Apt #)

_____ _____ _____
(City) (State) (Zip)

Date of Birth: _____/____/____ Social Security Number: _____ - ____ - _____
(mo) (day) (year)

Contact Number: (_____) _____ - _____ Cell Phone Number: (_____) _____ - _____
(other than cell phone)

1. Does the Patient have a Legal Conservator? ☐ Yes ☐ No

If "yes" to question #1 above, Please give the name and address of the Conservator:

CONSERVATOR'S NAME:: _____ _____
(First Name) (Last Name)

Address: _____ _____
(Street Number and Street Name). (Apt #)

_____ _____ _____
(City) (State) (Zip)

Conservators Relationship to Patient: _____

2. Is the Patient under 18 years of age? ☐ Yes ☐ No

If "Yes" to question # 2 above, please answer the following questions:

Name of Patient's Parent or Guardian: _____ _____

Date of Birth: _____/____/____ Social Security Number: _____ - ____ - _____
(mo) (day) (year)

Contact Number: (_____) _____ - _____ Cell Phone Number: (_____) _____ - _____
(other than cell phone)

NOTE: ALL THE QUESTIONS BELOW REFER TO THE PATIENT IF THE PATIENT IS 18 YEAR OF AGE OR OLDER, OR TO THE PARENT/GUARDIAN IF THE PATIENT IS YOUNGER THAN 18 YEARS OF AGE

SECTION II: EMPLOYMENT

3. Are you currently employed, or were you employed at the time you had your medical service?

☐ Yes ☐ No

If you answered "yes" to question #3 above, please check one of the following boxes:

☐ I am self employed ☐ My employer has less than 25 employees ☐ My employer has 25 to 50 employees

☐ My Employer has over 50 employees

4. Does your Employer offer Health Insurance to its employees? ☐ Yes ☐ No

If you answered "yes" to question #4 above, do you have Health Insurance through your Employer?

☐ Yes ☐ No

5. Are you married or have a domestic partner? ☐ Yes ☐ No

If you answered"yes" to question #5 above, please answer the following questions:

6. Is your spouse/domestic partner currently employed, or was employed at the time you had your medical service? ☐ Yes ☐ No

If you answered "yes" to question # 6 above, please check one of the following boxes:

☐ Is self employed ☐ His/Her employer has less than 25 employees ☐ His/her has 25 to 50 employees

☐ His/Her Employer has over 50 employees

7. Does his/her Employer offer Health Insurance to its employees? ☐ Yes ☐ No

If you answered "yes" to question # 7 above, does he/she have Health Insurance through the Employer?

☐ Yes ☐ No

SECTION III: OTHER PROGRAMS

8. Have you ever applied for any of the following programs (please check any box which applies to you)

☐ MediCal ☐ Healthy Families ☐ MediCare ☐ State Disability

☐ Commercial Insurance ☐ Medically Indigent Adult Program (BAC)

☐ Victims of Violent Crime

9. Have you ever qualified for any of the programs listed in question # 8 above? ☐ Yes ☐ No

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SECTION IV: FAMILY INFORMATION

10. Please list the name of all members of your family who are residing in your household:

Spouse/Domestic Partner: _____ Age: _____

Child: _____ Age: _____

Child: _____ Age: _____

Child: _____ Age: _____

Child: _____ Age: _____

(attach additional sheets if necessary)

Other members of Household:

Name: _____ Age: _____ Relationship to you: _____

(attach additional sheets if necessary)

11. Are you living in the residence of your parent or another adult member of your family

☐ Yes ☐ No

If you answered "yes" to question # 11 above, do you pay rent to that adult member?
☐ Yes ☐ No

12. Do you rent a room or other space in your home to any other adult, including members of your family? ☐ Yes ☐ No

13. Do you receive all or some support from other adult member(s) of the residence?
☐ Yes ☐ No

14 Are you receiving outside income for other expenses:

☐ Living ☐ School ☐ Medical Bills ☐ Other: _____

Estimated Amount: $_____ / month or $ _____/ year

15. Are you currently attending school? ☐ Yes ☐ No

16. Does a parent or guardian claim you as a dependent on their income tax? ☐ Yes ☐ No

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SECTION V: INCOME/ASSETS

17. Do you own any property? ☐ Yes ☐ No

If you answered "yes" to question # 17 above, please list the addresses or location of your property (list location if the property has no specific address)

Property: _____

Property: _____

(attach additional sheets if necessary)

Do you have/own any of the following: (Mark all that apply to you)

☐ Home	☐ Rental Property	☐ Checking Account
☐ Credit Cards	☐ Saving Account	☐ Retirement Account
☐ Investment Account	☐ Stocks/Bonds	☐ Safe Deposit Box

SECTION VI: SUPPORTING DOCUMENTS

Please attach the following documents to this application:

Tax Return for the most current year (if you did not file a tax return, please contact

your patient Account Representative)

Bank Statements for all: Checking Accounts & Savings Accounts

Statements for all: Retirement Accounts & Investment Accounts

Most current W-2's

SECTION VII: PATIENT STATEMENT

Please add any additional information you would like to have considered:

SECTION VIII

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Signature of Person Applying

Date