



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

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

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