Instructions

1. Please complete all areas on the attached application form. If any area does not apply to you, write N/A in the space provided. Please complete application within 90 days from date of service

2. Attach an additional page if you need more space to answer any question.

3. Please submit most current:
   a. Federal income tax return (Form 1040) from the most recent year. You must include all schedules and attachments as submitted to the Internal Revenue Service;
   b. If income has decreased per reported income on your Federal Income Tax Return, please provide most recent income stubs for both spouses (if applicable) along with Federal Income Tax Return.
   c. If you did not file a federal income tax return, please provide the following:
      - Two (2) most recent paycheck stubs; and
      - A letter explaining why you do not file a federal income tax return.

4. If you receive any of the following: SSI / DISABILITY / UNEMPLOYMENT / CHILD SUPPORT / ALIMONY / CASH AID / FOOD STAMPS. Please attach proof of income along with Federal Income Tax Returns.

5. If you have no source of income we will need a letter stating how you support yourself. If you state you receive support from an individual please attach a letter from the person you stated you receive support from.

6. If you are uninsured you may be eligible for a government sponsored program. Please provide a letter of eligibility determination from a county program if uninsured before applying for financial assistance.

7. Application must be signed by all party's providing documentation.

   Please note financial assistance policy does not apply to:
   a. Patients with a Medi-Cal Share of Cost
   b. Future services are not accepted; services must be rendered before application can be processed.
   c. Out of county residents are eligible for emergency cases only.
   d. Sequoia Prompt Care services are not applicable
   e. Separately billable physician services such as a primary care physician or California Emergency Physicians (Emergency Room Physicians).

8. Mail Application to:

   Kaweah Delta Health Care District
   400 W. Mineral King Ave.
   Visalia, CA 93291

CVBF 1070 Rev. 6/18

Patient Financial Services
Is located in the Acequia Lobby
on the corner of Floral and Acequia.

305 W. Acequia Ave.
Visalia, CA 93291

The Patient Financial Services Department is available to assist you with any questions concerning your application.

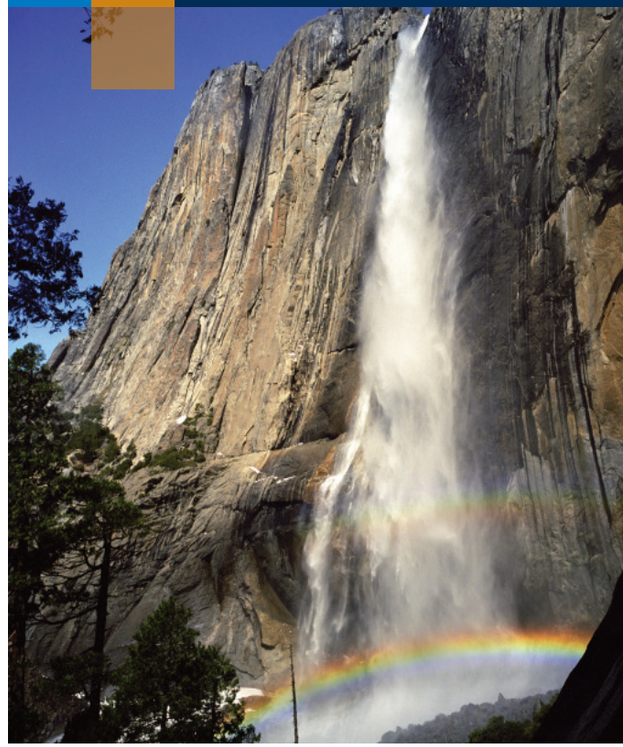
(559) 470-0016
or
toll-free 1-844-262-8636

Office Hours
Monday – Friday
8 am to 5 pm

Kaweah Delta
HEALTH CARE DISTRICT
More than medicine. **Life.**

400 W. Mineral King
Visalia, CA 93291
Phone (559) 624-2000

More than medicine. **Life.**



Financial Assistance Application

Kaweah Delta
HEALTH CARE DISTRICT

Kaweah Delta Health Care District

FINANCIAL ASSISTANCE APPLICATION

Account #

Patient Name | Spouse Name

Date of Birth | Date of Birth

Parent / Responsible Party Name

ADDRESS | PHONE

City | State | Zip | Home | Work

SOCIAL SECURITY NUMBER

Patient/ Guarantor | Spouse

FAMILY STATUS

List all dependents that you support

Name	Age	Relationship
Name	Age	Relationship
Name	Age	Relationship
Name	Age	Relationship
Name	Age	Relationship
Name	Age	Relationship

EMPLOYMENT STATUS

Patient/Guarantor Employer | Position

Contact Person | Telephone

Spouse Employer | Position

Contact Person | Telephone

INCOME

	Patient/Guarantor	Spouse
1. Gross Wages & Salary/Year (before deductions)		
2. Self-Employment Income/Year		

OTHER INCOME:

	Patient/Guarantor	Spouse
3. Interest & Dividends		
4. Real Estate Rentals & Leases		
5. Social Security		
6. Alimony		
7. Child Support		
8. Unemployment/Disability		
9. Public Assistance		
10. All Other Sources (attach list)		
Total Income (add lines 1 - 10 above)	$	

UNUSUAL EXPENSES

Please provide information on any unusual expenses such as medical bills, bankruptcy, court judgments or settlement payments (attach list as needed).

Description	Amount
Description	Amount
Description	Amount

If partial financial assistance is granted, what is the monthly payment you can afford to pay the hospital/clinic? Amount

By signing below, I/we declare that all information provided is true and correct to the best of my/our knowledge. I/we authorize Kaweah Delta Health Care District to verify any information listed in this application. We expressly grant permission to contact my/our employer.

Signature of Patient/Guarantor | Signature of Spouse

Date | Date