Dear Patient,

As part of its commitment to serve the community, Fresno Surgical Hospital has elected to provide financial assistance to individuals who meet certain low or moderate income requirements and lack or have inadequate insurance coverage.

To determine if a person may qualify for financial assistance, we need to obtain certain financial information as outlined within this application. Your cooperation will allow us to give all due consideration to your request for financial assistance.

If you would like to apply for our Discount Payment Program or our Charity Program, please complete the attached application and return with income verification to include:

1. Verification from all income sources
2. Verification of your current bank balance(s)
3. Last Year's Federal Tax Return (form 1040, 1040a or 1040ez)
4. If you are self-employed, please contact our Patient Accounting office to discuss income verification requirements
5. If you cannot provide any of the above required information, please provide a written explanation

The completed application and income verification may be returned to the Fresno Surgical Hospital Registration Representative, or mailed to the following address:

Fresno Surgical Hospital
Attn: Patient Accounting
6121 N. Thesta Drive Ste 101
Fresno, CA 93710

Upon receipt of your completed application and income verification, the Patient Accounting Department will notify you of determination of eligibility within thirty (30) days.

Should you have any questions regarding the application process, please contact our Patient Accounting Department at (559) 431-8000.

Sincerely,

Patient Accounting

Fresno Surgical Hospital
Financial Disclosure Statement

Applicant Information

Applicant Name:_____ SS#_____ Date of Birth:_____

Co-Applicant Name:_____ SS#_____ Date of Birth:_____

Number of persons who are legal **dependents** whether or not they reside in home:_____

Monthly Gross Income

Applicant: $_____ Co-Applicant: $_____
(Employment wages, Social Security, Pension, etc.)

Other Household Income: $_____ (*Child Support, Interest, Rent, etc.)*

Total Monthly Income: $_____

Monthly Expenses

Living Expenses:	$_____	Mortgage, Food, Utilities, etc.
Installment Payments:	$_____	Auto, Credit, Loans, etc.
Other Expenses:	$_____	Insurance premiums, Child Care, etc.

Total Monthly Expenses: $_____

Estimate patient's out of pocket expenses for medical care in the ***past 12 months:*** $_____

Bank Accounts

Checking Account Balance: $_____ Savings: $_____

Other Monetary Assets Cash Value: $_____ (*401k, Stocks, CD, Life Ins., etc.)*

Please have applicant(s) answer the following questions:

Have you applied for any government sponsored medical programs (even if denied) within the past 6 months?	(Y)	(N)
Are you the beneficiary of a trust fund and/or inheritance?	(Y)	(N)
Are you purchasing or own any real estate property other than your primary residence?	(Y)	(N)
Are any of the services provided by FSH related to an automobile or work related accident?	(Y)	(N)

If you have answered YES to any of the above questions, please explain:

_____
_____
_____

Fresno Surgical Hospital
Financial Disclosure Statement

Please attach a copy of your latest Federal Tax Return, Income verification and Bank Statements.

I hereby submit the above Financial Disclosure Statement for the purpose of allowing Fresno Surgical Hospital to evaluate my financial status and determine my eligibility for the financial assistance program, and do hereby authorize Fresno Surgical Hospital to verify this information as necessary, which may include a credit bureau report, employment and/or income verification, and appropriate supporting documents.

I attest that the above information and all income documentation provided are complete and accurate as shown. I am aware that falsification of information on this application may result in denial of financial assistance.

I further understand that the physicians providing services are not employees of the hospital. I understand that I will receive separate bills from my private physician and from other physicians whose service I required and that any assistance granted by Fresno Surgical Hospital exclude these physician charges.

_____ _____
Signature of Applicant Date

_____ _____
Signature of Co-Applicant Date

Please return this application and supporting documentation to:

Fresno Surgical Hospital
Attn: Patient Accounting
6121 N. Thesta Drive Ste 101
Fresno, CA 93710