Patient Name: _____ DOB: _____

Medical Record #_____

Patient Financial Services – PCX-103
9300 Valley Children's Place
Madera, CA 93636

Thank you for your interest in the Financial Assistance Program.
Please complete the following application and return with the required documentation within 15 days. Applications can be mailed to the address above or emailed to patientfinservices@valleychildrens.org. For assistance completing this application or additional questions please call 559-353-7009 or 800-956-2445.

Please include the following documentation with your completed application:

	Proof of residence (Utility, Cable or Phone Bill)
	Verification of Family Size (Copy of most recent income tax return-all pages)
	Recent one (1) month of pay stubs from all employed adults, statement of wages on company letterhead, or award letter from unemployment/disability
	Current Bank Statement (Checking & Savings- all pages)
	Notice of Action from Government Sponsored Insurance Program
	Hardship Letter
	Any other documentation requested to process your Financial Assistance application

Patient Information:

Patient Name:	Date of Birth:
Account Number/s:	

Applicant/Guarantor:

Relationship to Patient:	
Name:	
Address:	
City/ State/Zip:	
Home Phone:	Cell Phone:

Co-Applicant/Guarantor:

Relationship to Patient:	
Name:	
Address:	
City/ State/Zip:	
Home Phone:	Cell Phone:

Family Size: #_____

List all dependents that you support (Other than Self or Co- Applicant)

Name	Age	Relationship

Employment Information:

Applicant/Guarantor:

Employer:	
Business Name (If Self Employed):	
Position:	
Contact Person:	Phone Number:

Co-Applicant/Guarantor:

Employer:	
Business Name (if Self-Employed):	
Position:	
Contact Person:	Phone Number:

Additional Employer information:
Applicant/Guarantor or Co-Applicant/Guarantor:

Employer:	
Business Name (if Self-Employed):	
Position:	
Contact Person:	Phone Number:

Patient Name: _____ DOB:_____

Medical Record #_____

Valley Children's HEALTHCARE

INCOME & EXPENSES STATEMENT

INCOME List all income	**Applicant/Guarantor**	**Co-Applicant/Guarantor**
Gross Pay (before deductions)	$	$
Income from Operating Business (If Self Employed)	$	$
Interest and Dividends	$	$
From Real Estate or Personal Property	$	$
Social Security	$	$
Spousal/Child Support Received	$	$
Other Income (Specify):	$	$
Add Income from all Sources	$	$
TOTAL INCOME COMBINED (Applicant/Co-Applicant)	$	
EXPENSES FOR DONATION/SAVINGS		**COMMENTS**
Donations	$	
Savings	$	
Other	$	
Spousal/Child Support Paid	$	
LIVING EXPENSES		
Rent/Mortgage Payment	$	
Utilities	$	
Food	$	
Transportation	$	
Insurance	$	
Medical	$	
Clothing	$	
Entertainment	$	
Revolving Account/s	$	
Car Payment/s	$	
List all other expenses:		
	$	
	$	
TOTAL EXPENSES	$	
AVAILABLE INCOME	$	Subtract Expenses from Income

Medical Expenses:

Out-of-pocket expenses paid by either the Applicant or Co-applicant on behalf of the patient within the last twelve (12) consecutive months.	$

Valley Children's HEALTHCARE

I certify the above information is true and accurate. I understand that the information submitted may be subject to verification by Valley Children's Healthcare and reviewed by Federal and/or State Enforcement Agencies. The undersigned agrees to show proof of this information if so required. Additional information may be requested.

_____

Signature of Applicant/Guarantor Date

_____

Signature of Co-Applicant/Guarantor Date

Valley Children's Healthcare granting of Financial Assistance does not apply to professional services provided to Valley Children's patients by physicians or other medical providers including but not limited to Radiology, Anesthesiology, Pathology or Hospitalist services.

For Office use only:

Rec'd Application Date: _____ Initials_____

Missing Documentation _____ Complete Documentation_____

Scanned Application: _____ Date: _____ Initials_____