

Salinas Valley Memorial Hospital Financial Assistance Application

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.
2. Attach an additional page if you need more space to answer any question.
3. You *must* provide proof of family income when you submit this application. The following documents are accepted as proof of income:

If you filed a federal income tax return you must submit a copy of:

- 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;

If you did not file a federal income tax return, please provide the following:

- a. Two (2) most recent paycheck stubs; and
- b. A letter explaining why you do not file a federal income tax return.

If you have no income, please provide a letter explaining how you support yourself / family.

4. Your application cannot be processed until *all* required information is provided.
5. It is important that you complete and submit the financial assistance application along with all required attachments within fourteen (14) days.
6. You *must* sign and date the application. If the patient / guarantor and spouse provide information, both *must* sign the application.
7. If you have questions, please call your account representative.
8. Send or return you completed application to:

Salinas Valley Memorial Hospital
Patient Financial Services Department
558 B Abbott Street
Salinas, CA 93901
831-755-0732

EMPLOYMENT STATUS

EMPLOYMENT STATUS	
Patient / Guarantor Employer	Position
Contact Person	Telephone
Spouse Employer	Position
Contact Person	Telephone

FAMILY INCOME

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

By signing below, I/we declare that all information provided is true and correct to the best of my/our knowledge. I/we authorize Salinas Valley Memorial Hospital 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



Salinas Valley
Memorial
Healthcare System

450 East Romie Lane, Salinas, CA 93901
(831) 757-4333 • Toll free (888) 755-7864

A Public District Hospital