Coast Plaza Doctors 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 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. You must provide proof of monetary assets, such as bank statements or other documents that indicate amounts owned by the patient or family representative.

5. Your application cannot be processed until *all* required information is provided. 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 your completed application to:

   Coast Plaza Doctors Hospital
   Patient Financial Services Department
   13100 Studebaker Road
   Norwalk, CA 90650

Coast Plaza Doctors Hospital
Financial Assistance Application

PATIENT/ GUARANTOR NAME		**SPOUSE NAME**	
ADDRESS		**PHONE**	
		Home	
		Work	
SOCIAL SECURITY NUMBER			
Patient/ Guarantor		**Spouse**	

FAMILY STATUS **List all dependents that you support**		
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		
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**

MONETARY ASSETS	
Please provide an accurate statement of value for each asset you own.	
Asset	**Value**
1. Checking Accounts	
2. Savings Accounts	
3. Certificates of Deposit	
4. Stocks and Bonds	
5. Other Bank Accounts & Investments	
6. Other Monetary Assets (attach list)	
Total Amounts (add lines 1 – 6 above)	

By signing below, I/we declare that all information provided is true and correct to the best of my/our knowledge. I/we authorize Coast Plaza Doctors 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