FINANCIAL ASSISTANCE APPLICATION INSTRUCTIONS

PLEASE NOTE, THIS FORM DOES NOT APPLY TO THE STATE OF CALIFORNIA MEDI-CAL PROGRAM

CHOC Children's requires the attached application and the supporting documents listed below to properly evaluate your request for a possible reduction of hospital expenses incurred at CHOC Children's in Orange or CHOC Children's at Mission Hospital.

Please complete all sections of the application. The documents listed as required must be included with your application. Any application that is missing information or that is submitted without the required supporting documents will be returned to you.

Please submit your complete application and required documents to:

CHOC Children's
Patient Financial Services Department
1201 W. La Veta Ave
Orange, California 92868-3874

If you need to contact the hospital regarding your application please call 714-509-7860.

The current published federal poverty guidelines are used in determining eligibility. CHOC Children's Financial Assistance policy is available upon request.

ATTENTION: THE FOLLOWING DOCUMENTS ARE REQUIRED.

These forms must be submitted along with your Financial Assistance application.

① **The two (2) most recent pay check stubs**
② **Bank Statements from the past two (2) months**
③ **Federal Income Tax returns from the previous year**

Please provide documentation that supports the following sources of Other Income, Assets or Other Resources:

Social Security
Workers Compensation
Welfare/AFDC
Alimony
Child Support
Rents
Support from family members or someone not living in the household
Tax refund entitlements
Stocks
Bonds
Trust Funds
Property (other than primary residence)

Personal Information
A

Pt. Label

Patient Name:		
Sex: ☐ Male ☐ Female		**Patients SS#**
Patients date of birth:		**Account Number**
Guarantor Name:		
Address:		
Does the patient have medical insurance?	**Yes**	**No**
Has patient applied for Medi-Cal or CCS?	**Yes**	**No**
Total Number of Family Members: (Include all children 21 and under)		**Family Members Ages:**
Is Patient a California Resident?	**Yes**	**No**
Is this for an Emergency Room Visit?	**Yes**	**No - If yes 1011 Form needs to be given**

I certify that the information provided is true and accurate to the best of my knowledge. Further, I have or will apply for any assistance (Medi-Cal, Healthy Families, insurance, etc.) which may be available for payment of medical services, and that I will take any action reasonably necessary to obtain such assistance and will assign or pay to the hospital the amount recovered for medical services.

I understand that this application is a tool for the hospital to evaluate eligibility for financial assistance services. I also understand that the hospital will verify the information which may include obtaining a credit report. If the information I have given proves to be untrue, or if I fail to comply with the referral process for MediCal, Medicare, California Children's Services, or other identified programs this may result in forteiture of the right to be considered for the Financial Assistance Program.

Todays Date:_____ Date(s) of Service:_____

Signature: _____

Name: _____

Address: _____

_____

Telephone Number : _____

Assets/Income/Resources
B

Employee/Employer Name	Employer Information	Monthly Income (prior to taxes)	Hire Date
(Mother) Employee Name:	Address:		
Telphone Numuber:		$	
(Father) Employee Name:	Address:		
Telphone Numuber:		$	
(Other Employment Income)	Address:		
Telphone Numuber:		$	
Annualized Income:		**$**	

Assets and Resources

Funds	Description	Value	
Checking:	Account Number:		
Savings:	Account Number:		
Investments	**Description**	**Value**	
Money Market Funds:	Type:		
Stocks:	Type:		
Bonds:	Type:		
Personal Property	**Description**	**Value**	**Equity**
Property (other than primary residence)	Type:		
	Type:		
Assets and Resources:	Type:		