APPENDIX B

HENRY MAYO NEWHALL HOSPITAL
FINANCIAL ASSISTANCE PROGRAM APPLICATION

Date:

Patient Name
Patient Address
City, State, Zip

Patient Name:
Patient Account:
Date of Service:

Financial Assistance Program

Dear _______________:

Thank you for choosing Henry Mayo Newhall Hospital (HMNH) for your health care needs, where we strive to improve the health of our community through compassion and excellence in health care services. You may be eligible for financial assistance to assist you in paying health care services you will or have received at HMNH. This financial assistance applies to your hospital bill only, and does NOT apply to bills you may receive from your physicians or surgeons, although if this application is approved, some providers may extend a full or partial courtesy discount based upon the hospital acceptance determination letter.

Enclosed, please find an application for financial assistance which must be filled out in its entirety, proper documentation enclosed, signed and dated so that the review process may commence.

The application and required information is provided below. Please submit the requested documents to Patient Access Services in person or by mail to:

Henry Mayo Newhall Hospital
23845 Mc Bean Pkwy
Valencia, CA 91355.
Attn: Patient Access Financial Counselors

You will receive a determination of Eligibility for Financial Assistance letter within thirty days after we receive a completed application with appropriate supporting documents.

Completion of this application is not a guarantee of eligibility or qualification for financial assistance or any other program. Financial assistance is considered after all possible sources of potential payment (for example, health insurance, Medicare, Medicaid, liability insurance) have been exhausted. Failure to provide requested documents may result in denial of the application.

If you need any further information or assistance in completing the application, please make an appointment to come to the hospital at Patient Access Services, Main Admitting, or call 661-200-1050, Monday through Friday, 7:00 AM through 5:00 PM and a representative will assist you. For more information about the Financial Assistance Program, you may visit our website at: https://www.henrymayo.com/images/FAP-Policy.pdf

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(signature line)

(printed name of financial counselor)
Financial Counselor

HENRY MAYO NEWHALL HOSPITAL
FINANCIAL ASSISTANCE PROGRAM APPLICATION FORM

Physician: Medical Record #: Date(s) Of Service:

PATIENT INFORMATION:
Patient Account:
Patient Name:
Patient Home Address:

Social Security#: Phone#: Birthdate:

Third party coverage (i.e., Medi-Cal, Medicare, private insurance, etc.), which may partially or fully cover the cost of health insurance received on the above date(s). Yes_____ No_____

Place of Birth
City: _________________________ State: _______________
Mother's Maiden Name _____________________________

If you were born outside the United States, have you applied to or received Amnesty under Federal law? Yes_____ No_____ Amnesty #__________________

Name(s) and age(s) of dependents living with you for whom you are responsible:

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____

Total Household Monthly Income

$: ______________________________

INCOME: List income for family from:

	Monthly	Annually
Wages (self)....................	$____________________	$____________________
(Spouse)	$____________________	$____________________
(Other family member).....	$____________________	$____________________
Farm/self-employment............	$____________________	$____________________
Public Assistance...............	$____________________	$____________________
Unemployment Compensation...	$____________________	$____________________
Workman's Compensation..........	$____________________	$____________________
Strike Benefits.................	$____________________	$____________________
Alimony.........................	$____________________	$____________________
Child Support...................	$____________________	$____________________
Military family allotment.......	$____________________	$____________________
Pension(s).....................	$____________________	$____________________
Income from rent, interest,	$____________________	$____________________
dividends	$____________________	$____________________
Social Security Income	$____________________	$____________________
Income from Interest/Rental	$____________________	$____________________
TOTAL	$____________________	$____________________

EXPENSES (MONTHLY)	$____________________
Mortgage/Rent	$____________________
Medical Insurance:	$____________________
Utilities:	$____________________
	$____________________
Electricity	$____________________
	$____________________
Gas	$____________________
	$____________________
Water	$____________________
Home/Renter's Insurance	$____________________

Auto Insurance: $____________________
$____________________
Telephone: $____________________
Medical Bills $____________________
Food/Groceries: $____________________
Hospital: $____________________
Credit Cards $____________________
Physicians: $____________________
Credits Union: $____________________
Prescriptions: $____________________
Auto loans: $____________________
Life Insurance: $____________________
Auto gasoline: $____________________
Health Insurance: $____________________
TV/Cable: $____________________
Medical Bills: $____________________
Child Care: $____________________
School expense: $____________________
School Expense: $____________________

TOTAL EXPENSES: $____________________

Do you own your own home? Yes____ No____Estimated Value $_____________
Do you own other property? Yes____ No____Estimated Value $______________
Do you own an automobile? Yes____ No____
Stocks, Bond, Mutual Funds Yes____ No____Estimated Value $_____________
401K and Annuities Yes____ No____Estimated Value $_____________
Savings Account 1 Yes____ No____Estimated Value $_____________
Savings Account 2 Yes____ No____Estimated Value $_____________
Checking Account Yes____ No____Estimated Value $_____________

The following information is required to be submitted with your application:

Proof of income (for each household member, provide all documents that exist or apply).

- Copy of the three most recent paystubs. If paid in cash, a notarized letter from each employer indicating terms of employment including wages, salary, dates of employment, current employment status, the availability of any health care benefits, etc.

- If self-employed, the latest tax returns.
- Copies of checks or award letters from unemployment, Social Security.
- Copies of checks for child or spousal support.
- Proof of other income (for example, interest income, pension, or rental income).
- Copy of the most recently filed income tax return.
- Photo ID/Proof of Identification
- Current Driver License, or
- Current State ID, or
- Current Passport

DISCLOSURE OF ASSETS (for each household member, provide all documents that apply)

- Past three months of detailed statements from Checking and Savings accounts, Certificates of Deposit, Money Market Fund, Brokerage Statement, Retirement Plan, and/or title of Vehicle(s) owned.

EXPENSES

- Copy of rent lease (for the last 6 months)/mortgage agreement, most recent statements for all monthly expenses such as utility bills, credit card statements, car payments and/or any other that may apply.

YOUR SIGNATURE IS REQUIRED TO COMPLETE THIS APPLICATION.

My signature attests that the information I have provided on this form is accurate and true to the best of my knowledge.

____ ______/______/________

Patient/Responsible Relative(s) Signature Date

____ ______/______/________

Hospital Reviewer Date