VALLEY PRESBYTERIAN HOSPITAL

FINANCIAL ASSISTANCE APPLICATION FORM

Provided in Accordance with Cal. Health & Safety Code § 127425(e)(5)

Application Date:	Date of Service:
Patient Name:	Account Number:
Street Address:	Phone Number:
City, State, Zip	Patient Date of Birth:
Patient's/Guarantor's email address:	

Please call 1-818- 902-2913 for any questions about filling out this form.

INCOME:

- All adult family members' income must be disclosed. Income includes gross (before taxes) wages, rental income, unemployment compensation, social security benefits, public assistance, dividends and interest, etc.
- "Family" is defined as follows: (i) for persons 18 years of age and older, family means spouse, domestic partner and dependent children under 21 years of age, whether living at home or not; and (ii) for persons under 18 years of age, family means parents, caretakers, relatives, and other children under 21 years of age of the parent or caretaker relative. If the patient is a minor, the "family" is defined as the patient, the patient's natural or adoptive parents and the parent's other children (natural or adoptive) who live in the patient's home.

Family Member's Name	Age	Date of Birth	Relationship to Patient	Source of Income or Employer Name	Income in the last 3 months	Social Security #
Total Household Income:						

**Please attach additional family member information if applicable.

- **Proof of income must be supplied at the time of application (e.g. one month of pay stubs, most recent tax return (IRS Form 1040), etc.) and copy of bank statement.**
- If you report $0 income, please provide a written statement of how you (or the patient) are surviving financially, including who provides food, shelter, transportation, etc. and how long you have been without income.

HOMELESS AFFIDAVIT

I, ____ , hereby certify that I am homeless, have no permanent address, no job, savings, or assets, and no income other than potential donations from others.

________ Patient/Guarantor Initials.

UNINSURED DISCOUNT PROGRAM

I,____ , hereby request that if I may not be found eligible for any Medical
Assistance Program or granted Financial Assistance that I will be automatically deemed eligible for the Valley Presbyterian Hospital Uninsured Discount Program, if no third party coverage.

________ Patient/Guarantor Initials.

My signature below certifies that everything I have stated on this application is correct and subject to review under audit. I understand that if the information I provide is determined to be false, financial assistance may be denied and I may be responsible to pay for services provided.

____ ________________________

Applicant's Signature Date

Please return completed application to: Valley Presbyterian Hospital
P.O. Box 840417
Los Angeles, CA 90084-0417