0332

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 documents 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, or proof of income documents, please provide a letter explaining how you support yourself/family.

4. Your application for assistance 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 Financial Assistance Application. If the patient/responsible party and spouse provide information, both must sign the application.

7. If you have questions, please call the Patient Business Office at (909) 651-4177, between the hours of 9:00 a.m., and 3:00 p.m., Monday through Friday (excluding weekends and holidays).Weekends, holidays and after hours, please contact any Registration Representative for assistance.

8. Send you completed Financial Assistance Application and all required documents to:

   Loma Linda University Medical Center
   Patient Business Office
   P. O. Box 700
   Loma Linda, CA 92354

FINANCIAL ASSISTANCE APPLICATION INSTRUCTIONS

The purpose of this form is to determine patient/responsible party eligibility for financial assistance in accordance with the Loma Linda University Medical Center Charity Care/Discount Payment Policy.

PATIENT/RESPONSIBLE PARTY
(guarantor) **NAME** _____

SPOUSE
NAME _____

ADDRESS
_____
_____

PHONE
Home: _____
Work: _____

SOCIAL SECURITY NUMBER
Patient/Responsible party _____ **Spouse** _____

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

Name	Age	Relationship

EMPLOYMENT STATUS

Patient/Responsible party

Employer _____

Patient/Responsible party

Position _____

Employer

Contact Person _____

Employer Contact

Telephone _____

Spouse Employer _____

Spouse Position _____

Employer

Contact Person _____

Employer Contact

Telephone _____

INCOME

	Patient/Guarantor	Spouse
1. **Gross Wages & Salary/Year** (before deductions)	$	$
2. **Self-Employment Income/Year**	$	$
3. **Other Income:**		
a. **Interest & Dividends**	$	$
b. **Real Estate Rentals & Leases**	$	$
c. **Social Security**	$	$
d. **Alimony**	$	$
e. **Child Support**	$	$
f. **Unemployment/Disability**	$	$
g. **Public Assistance**	$	$
h. **All Other Sources (attach list)**	$	$
Total Income (add lines 1 - 3h 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 LLUMC to verify any information listed in this application. I/we expressly grant permission to contact my/our employer.

Signature of Patient/Responsible party _____ Relationship to Patient _____ Date _____

Signature of Spouse _____ Date _____