MemorialCare Medical Group

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:

    a. Two (2) most recent paycheck stubs including any Social Security (award letter acceptable), child support, unemployment, disability, alimony, and/or evidence of other payments deposited directly into your bank account). **If not available, then;**
    b. Last filed Federal income tax return (Form 1040), including all schedules and attachments as submitted to the Internal Revenue Service with Federal W-2 Form(s) showing wages and earnings, or:
    c. If you are paid only in cash, have no income or cannot provide any of the above, please submit a written statement explaining your income sources and how you support yourself.

4. It is important that you complete, sign, and submit the financial assistance application along with all required attachments within fourteen (14) days.

5. Your application cannot be completely processed until *all* required information and documents have been provided. **If all requested documentation is not received within 30 days of application signature date, you may be required to re-submit the application and accompanying documentation.**

6. **If you are legally married, you and your spouse must sign and date the application.**

7. If you have questions, please call our Patient Billing Services department.
    - Patient Billing Services - 8:30AM – 5:00PM, Monday – Friday……………...…..(657) 241-3601

8. Once complete, please return the application with the required documents to:
    - MemorialCare Medical Foundation,
      ATTN: Billing Services, 17360 Brookhurst Street, Fountain Valley, CA 92708

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Financial Assistance Application

ACCOUNT NUMBER: ______________________________

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

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INCOME

	Patient/Guarantor	Spouse
1. Gross Wages & Salary (before deductions)		
2. Self-Employment Income		
Other Income:		
3. Interests & 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)		

ASSETS

Please provide an accurate estimate of value for each asset you own. Also, indicate how much you owe on any outstanding debt related to each asset listed.

Asset	Value	Amount Owed
1. Primary Residence		
2. Other Real Estate (attach list)		
3. Motor Vehicles (attach list)		
4. Other Personal Property		
5. Bank Accounts & Investments		
6. Retirement Plans		
7. Other Assets (attach list)		
Total Amounts (add lines 1 – 7 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 MemorialCare Medical Foundation to verify any information listed in this application. I/We expressly grant permission to contact my/our employer, banking, and lending institutions. In addition, my/our credit report may be obtained.

Signature of Patient/Guarantor

Signature of Spouse

Date

Date