CASA COLINA
Hospital and Centers for Healthcare

Financial Assistance Application

Date: _____

Patient /Guarantor Name: _____

Address: _____

_____

Please complete and provide all requested information to the best of your abilities in order for Casa Colina Hospital and Centers for Healthcare to accurately determine if you qualify for our Financial Assistance Program, which is based on Federal Poverty Guidelines.

- ✓ Completed and signed Financial Assistance Application
- ✓ Award letters for Social Security, SSI, Disability, Unemployment, General Relief, Alimony, etc.
- ✓ Most recent tax returns
- ✓ Pay stubs (most recent available)
- ✓ Employment status, both current and future; or, if self-employed, current year-to-date profit and loss statement to determine current income
- ✓ Family size
- ✓ Last two months' bank, brokerage and investment statements
- ✓ Copies of prior year's 1099 for interest income, dividends, capital gains, etc.
- ✓ Other appropriate financial data if tax returns or pay stubs are not available. Certain assets—such as retirement plans, homes, and automobiles owned by the patient—are excluded.
- ✓ Rent verification
- ✓ Property/mortgage verification

Please note that any incomplete application will be denied and sent back to you for completion and/or supporting documentation. If you have any questions, please contact our **Patient Financial Services Department** at **909/596-7733, ext. 5558**. Faxed requests can be faxed to **909/450-0141.**

Enclosure: [ ] Application: [ ]

For Casa Colina Internal Purposes Use Only

Please complete the below information prior to providing the application to the applicant. For questions or clarification, please contact the **Director of Patient Financial Services** at ext. 5558.

Department:	
Team Number:	
Date Application was given to the Applicant:	
Internal Requestor:	

Financial Assistance Application

Patient's Name: _____ Phone: (_____) _____

Address: _____ Date of Birth: _____

_____ Sex: ☐ Female ☐ Male

Social Security No: _____

SECTION 1: FAMILY INFORMATION

List all persons living in the household who are related by birth, marriage, and/or adoption. Include related college students who do not reside with family but are supported by the family.

Name	Date of Birth	Sex	Relationship	Social Security No.

SECTION 2: GROSS MONTHLY INCOME

List all employers for each member of household and attach proof of gross income (before taxes or deductions). Examples of proof of income: income tax return or check stub(s), profit/loss statement from accountant (for self-employed persons).

Name	Employer Name, Address, & Phone Number	Monthly Income

List all other income including social security, railroad retirement, unemployment compensation, worker's compensation, welfare/AFDC, supplemental security income, alimony, child support, military allotment, support from an absent family member or someone not living in the household, private or government pensions, insurance or annuity payments, income from dividends, interest, rents, royalties, and/or estates/trusts. Please attach proof of income.

Source of Income	Monthly Income

SECTION 3: MONTHLY INCOME

Briefly describe your employment status including date of hire and/or last date of employment/retirement. If you are receiving income from other sources, describe the type of support, the date support began, and the date the support is expected to end, if applicable. Also, describe any other pertinent details about your income.

Identify ALL sources of monthly income for your household. Enter the person receiving the income and the amount received each month for each income category that is applicable. In addition to completing this application, for each type of income that you identify below, submit the required documentation listed AND your most recently filed tax return including ALL supporting schedules, two months of bank statements, savings account statements, and brokerage/investment statements.

OCCUPATION:	Required Documentation	Patient or Applicant	Spouse/Other Family
Wages	2 current pay stubs		
Hourly rate			
Average monthly hours worked			
Self-employment gross receipts	YTD P&L Schedule (1)		
Partnership income	YTD P&L Schedule (1)		
Social Security	Award		
Supplemental Security Income (SSI)	Award		
Unemployment	Award		
Disability	Award		
Workers compensation	Award		
General relief	Award		
Temporary Assistance for Needy Families (TANF)	Award		
Food stamps/Electronic Benefit Transfer (EBT)	Award		
Alimony	Award		
Child support	Award		
Student loans	Award		
Pension/Annuities	Last year's 1099		
Interest income	Last year's 1099		
Dividends	Last year's 1099		
Capital gains	Last year's 1099		
Gross rental income			
Other:			
TOTAL MONTHLY INCOME			

(1) YTD P&L Statement means the current year-to-date profit & loss statement for the business/partnership. If your family does not have income, in the space below, please describe how you have been able to meet your needs for food and shelter. If another person has been providing support, in addition to the below, please ask the person to send Casa Colina Hospital and Centers for Healthcare a letter describing the type of support, frequency, and duration of the support.

SECTION 4: MONTHLY EXPENSES	Patient or Applicant	Spouse/Other Family
Mortgage of owner-occupied residence		
Mortgage of rental property		
Rent		
Property taxes		
Car payment		
Childcare		
Cell phone		
Food & household supplies		
Car insurance & gas		
Clothing		
Medical & dental expenses		
Insurance		
Credit card payments		
Tuition		
Child support		
Spousal support		
Installment payments		
Laundry & cleaning expenses		
Other:		
TOTAL MONTHLY EXPENSES		

If the reported monthly expenses exceed reported income, explain how you are able to meet these financial obligations.

_____

_____

_____

Please state if the patient has applied for Medi-Cal or any other government programs. If yes, please provide information below:

Program Name: _____

ID/Policy #: _____

Date of Program:_____

Other: _____

_____

_____

SECTION 5: OTHER

Are you employed? ☐ Yes ☐ No Will you be employed in the future? ☐ Yes ☐ No

Have you filed bankruptcy? ☐ Yes ☐ No If so, when?

Also, please include any further information you feel might be helpful or make any statement you believe would assist us in reviewing your application.

_____

_____

_____

PURPOSE: The purpose of this information is to determine your ability to pay for services at Casa Colina Hospital and Centers for Healthcare or your possible eligibility for a medical assistance program. This information is NOT an application for Medi-Cal, County Medically Indigent Services Program, California Children Services, Healthy Families, or any other county assistance program.

YOU MUST CONTACT THE DEPARTMENT OF SOCIAL SERVICES IN YOUR COUNTY OF RESIDENCE TO APPLY FOR ASSISTANCE PROGRAMS.

I certify the above information to be accurate and complete, and that this application is made for Casa Colina and Centers for Healthcare to determine my eligibility for discounted or charity care. I understand that Casa Colina Hospital and Centers for Healthcare reserves the right to verify all information supplied, including permission to contact employers and to check my/our credit history. I agree to notify the Patient Accounting Department of any change in my financial information within 10 days of the change.

I UNDERSTAND THAT I MAY BE STILL RESPONSIBLE FOR THE FULL AMOUNT OF MY CHARGES AT CASA COLINA HOSPITAL AND CENTERS FOR HEALTHCARE.

Signature of Patient/Responsible Party: _____

Printed Name: _____ Date: _____

Signature of Casa Colina Hospital and Centers for Healthcare Representative: _____

Printed Name: _____ Date: _____