



Marian Medical Center

A member of CHW

Payment Assistance Application

Patient Account Number

Patient Last Name

Patient First Name

Patient Social Security #

Patient Date of Birth

Guarantor Last Name (If Different)

First Name

Guarantor Social Security #

Date of Birth

Guarantor Home Address

() _____
Home Telephone Number

City

State

Zip Code

Guarantor's Employer Name

\$ _____
Guarantor's Annual Income

Guarantor Job Function/Department

Guarantor's Employer Address

() _____
Guarantor's Employer Telephone

City

State

Zip Code

Spouse's Employer Name

\$ _____
Spouses Annual Income

Spouse's Job Function/Department

Spouse's Employer Address

() _____
Spouse's Employer Telephone

City

State

Zip Code

People In Household

| Name | Date of Birth | Employer | Employer Telephone |
|------|---------------|----------|--------------------|
| 1) | | | |
| 2) | | | |
| 3) | | | |
| 4) | | | |
| 5) | | | |
| 6) | | | |
| 7) | | | |
| 8) | | | |

CHW Payment Assistance Application (Continued)

Please complete the table below as completely as possible:

Income Analysis

In order to determine your eligibility for the CHW Payment Assistance Program please provide us with information about your annual before-tax household income.

| | |
|-----------------------------|-----------------|
| Job Income | \$ _____ |
| Spouse Job Income | \$ _____ |
| Business Income | \$ _____ |
| Rental Income | \$ _____ |
| Interest/Dividend Income | \$ _____ |
| Social Security Income | \$ _____ |
| Alimony or Support Payments | \$ _____ |
| Other Income | \$ _____ |
| Total Income | \$ _____ |

Qualified Monetary Asset Analysis

Please **do not** include any funds held in tax exempt/deferred accounts such as 401K savings accounts, 403B savings accounts, and IRA savings accounts.

| | |
|--|-----------------|
| Checking Account(s) | \$ _____ |
| Savings Account(s) | \$ _____ |
| Stocks, Bonds & CDs | \$ _____ |
| Other: _____ | \$ _____ |
| Other: _____ | \$ _____ |
| Other: _____ | \$ _____ |
| Other: _____ | \$ _____ |
| Other: _____ | \$ _____ |
| Total Qualified Monetary Assets | \$ _____ |

In order to determine who truly needs financial assistance, we must require the submission of information to demonstrate financial hardship. Please complete the attached application and return it with all of the following items. If you are unable to supply one of the documents, please submit a statement explaining why you cannot provide the information.

- 1) **Proof of Identity** - One of the following:
 - Copy of Social Security Card
 - Copy of state issued driver's license
 - Other photo ID
- 2) **Proof of Monetary Assets** - All of the following (if applicable):
 - Last two months checking account statements
 - Last two months of savings account statements
 - Documentation about stocks, bonds, and/or CDs
- 3) **Verification of Current Address** - One of the following:
 - Rent receipt
 - Utility Bill
- 4) **A copy of a state Medicaid/Medi-Cal/AHCCCS decision/denial notice (if applicable)**
- 5) **Proof of Income:**
 - If employed, include copy of prior year tax return, including W-2 or check copies or check stubs from each of the prior three months.
 - If receiving public assistance, include copies of public assistance checks from each of the prior three months or award letter (i.e. disability, unemployment pay stubs, or social security benefits.)
 - If employment income is received in cash, include a written statement from your employer stating your monthly income for the last three months.
 - If self-employed, include Schedule C of prior year tax return and a quarterly accountant report with a written statement declaring gross income received during the last three months.
 - If not receiving a consistent income, write a brief paragraph on a separate paper stating your financial situation over the last three months. Explain how or from what source you are receiving monies to pay for your basic living expenses such as food and housing.
 - If dependent upon another individual's financial support, include a "letter of financial support."

By signing below you indicate your desire to be considered for Payment Assistance. Additionally, you certify that all the statements made on this application are true and complete to the best of your knowledge. Catholic Healthcare West is hereby authorized to check references and credit history in order to evaluate this application for financial assistance consideration.

Signature of Person Responsible For Bill (Guarantor)

Date