

**Request For Financial Assistance Uncompensated Charity
Care / Discount Payment Program Application
Instructions**



Date _____

Patient Name _____

Account Number(s) _____

Total Balance for Consideration \$ _____

This application is for Community Memorial Hospital charges only.

All physicians including Community Memorial Health Centers physicians, radiologists, pathologists, anesthesiologists, emergency room physicians and ambulance services are billed separately from Community Memorial Hospitals and are not covered by this application.

The hospital may only request recent paystubs and/or income tax for documentation of income. The hospital may accept other forms of documentation of income but shall not require such other forms.

It is important that the application be complete, and all requested information is provided in order to properly assess your ability to pay all or part of the hospital bill. Patients who only apply for discount payment program eligibility may receive less financial assistance than what may be available to them under the charity care program.

Although we do not require a completed Medi-cal application to determine your eligibility; it is recommended that you complete a Medi-cal screening to offset any additional charges that is not covered by this application. If you choose to do so, you can contact the local Department of Health Services at 888-472-4463 or <https://benefitscal.com>

The following documents are required to process your application

1. Fully completed charity care/discount payment program application (enclosed with this letter)
2. A copy of the applicant's most recent period payroll check stubs within 6 months before or after the applicant was first billed by the hospital or in the case of preservice, when the application was submitted. Note that this also includes public assistance (for example, Social Security, Unemployment, or Disability). If you receive your income in cash, please provide us with a written statement from your employer stating your income.

If you currently are not receiving any income please write a brief paragraph on a separate sheet of paper stating your current financial situation. Be sure to include the date and signature. If you are receiving financial assistance or living with someone, please have him or her write a statement explaining the situation.

3. Rent or mortgage verification only required if seeking a payment plan. This is not required or considered for financial assistance eligibility.
4. Prior year's tax return for the year the applicant was first billed or the year before.
(the completed and signed 1040)

Send copies of these documents because they will not be returned to you.

Please submit your completed application and supporting documentation in person at any of our hospital locations or at our Business Office located at 5855 Olivas Park Drive Ventura, CA 93003.

For any questions, please contact us at 805-948-5615 for assistance.

Thank you,

Patient Financial Services Department
Community Memorial Healthcare

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Patient Name _____

Patient Account Number(s) _____

Guarantor Name _____

Date of Birth _____ SS# _____

Phone _____

Address _____

City, State, Zip _____

Spouse Name _____ SS# _____

Are you a U.S. Citizen? ____ Yes ____ No

If not, a resident alien? ____ Yes ____ No

If not, nonresident alien? ____ Yes ____ No

FAMILY STATUS List all dependents who you support

Name	Age	Relationship
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

Employer _____

Position _____

If self-employed, Name of business _____

Employer Address _____

Phone Number _____ How long employed _____

Spouse Employer _____ Position _____

If self employed, name of business _____

Statement of Current Income and Expenditures

Current Monthly Income

Patient

Spouse

Gross Pay	\$ _____	\$ _____
Income from business (if self-employed)	\$ _____	\$ _____
Interest and dividends	\$ _____	\$ _____
Income from real estate or personal property	\$ _____	\$ _____
Social Security/Retirement Income	\$ _____	\$ _____
Alimony, support payments	\$ _____	\$ _____
Unemployment compensation	\$ _____	\$ _____
Other Income	\$ _____	\$ _____
Total Monthly Income	\$ _____	\$ _____

Current Monthly Expenses	Patient	Spouse
Rent or House Payment	\$_____	\$_____
Real Estate Taxes	\$_____	\$_____
Utilities	\$_____	\$_____
Alimony, support payments	\$_____	\$_____
Education	\$_____	\$_____
Food	\$_____	\$_____
Payroll Deductions	\$_____	\$_____
Medical, dental and medicines	\$_____	\$_____
Other_____	\$_____	\$_____
Total Monthly Expenses	\$_____	\$_____
Net Monthly Income after Expenses	\$_____	\$_____

I understand that Community Memorial may verify my information by reviewing credit information and obtaining information from other sources to assist in determining eligibility for financial assistance or payment plans.

I affirm that the above information is true and correct to the best of my knowledge. I understand if the financial information I give is determined to be false, the result may be denial of financial assistance, and I may be responsible for and expected to pay for services provided.

 Signature of Patient or Guarantor

 Date

 Signature of Co-applicant

 Date