

## APPLICATION FOR FINANCIAL ASSISTANCE

PATIENT NAME \_\_\_\_\_ SPOUSE'S NAME: \_\_\_\_\_  
 ADDRESS \_\_\_\_\_  
 PHONE NUMBER (\_\_\_\_\_) \_\_\_\_\_

CONTACT PERSON & PHONE NUMBER: \_\_\_\_\_  
 If Self-Employed, Name of Business \_\_\_\_\_

SPOUSE EMPLOYER \_\_\_\_\_ POSITION \_\_\_\_\_  
 CONTACT PERSON & PHONE NUMBER \_\_\_\_\_  
 If Self-Employed, Name of Business \_\_\_\_\_

### CURRENT MONTHLY INCOME

|   | Patient | Other/Family |
|---|---------|--------------|
| (Add) Gross Pay (before deductions)                                   | _____   | _____        |
| (Add) Income from Operating Business (if Self-Employed)               | _____   | _____        |
| (Add) Other Income: Interest and Dividends                            | _____   | _____        |
| From Real Estate or Personal Property                                 | _____   | _____        |
| Social Security   | _____   | _____        |
| Other (specify):  | _____   | _____        |
| Alimony or Support Payments Received                                  | _____   | _____        |
| (Subtract) Alimony, Support Payments Paid                             | _____   | _____        |
| (Equals) Current Monthly Income                                       | _____   | _____        |
| Total Current Monthly Income (add Patient + Spouse) Income from above | _____   | _____        |

### FAMILY SIZE (Add Patient, Parents (for minor patients), Spouse, and Children from Above)

Total Family Members \_\_\_\_\_

|   | YES                      | NO                       |
|---|--------------------------|--------------------------|
| Do you have health insurance?   | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have other insurance that might apply (such as auto policy)?           | <input type="checkbox"/> | <input type="checkbox"/> |
| Were your injuries caused by a third party (a car accident, a slip, or fall)? | <input type="checkbox"/> | <input type="checkbox"/> |

By signing this form, I agree to allow Anaheim Community Hospital (ACH) to check employment for the purpose of determining my eligibility for a financial discount, I understand that I may be required to provide proof of the information I am providing in the form of recent pay stubs or tax returns. ARBH will consider other forms of proof of income if submitted.

\_\_\_\_\_  
 SIGNATURE                                      DATE                                      Signature of Spouse                                      DATE



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 ASSISTANCE**

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