hoag

Financial Assistance Application

Name	Date of Birth	Spouse/Partner	Date of Birth
Address		City	State / Zip
Time at Present Address Years: Months:		County	Marital Status
Do you Rent or Own: Rent: Own:			Married Single Divorced Widowed
Cell Number	Home Number	Spouse Cell Number	Spouse Work Number

Please list ALL persons living in your household; including dependents (Attached an additional sheet if needed)

Last Name, First Name, MI	Date of Birth	Relationship to Applicant
1		
2		
3		
4		

Self		**Spouse**	
Social Security #		Social Security #	
Employed By		Employed By	
Business Address		Business Address	
Occupation		Occupation	
Length Employed:		Length Employed:	
Years: Months: Hours Worked Per Week:		Years: Months: Hours Worked Per Week:	

Income: Represents total cash receipts from all sources before taxes.

Self-Monthly Gross		**Spouse Monthly Gross**	
Gross Income (Employment)		Gross Income	
Social Security /SSI/SSDI		Social Security/ SSI/SSDI	
Public Assistance		Public Assistance	
Rental Property Income		Rental Property Income	
Retirement/Pension		Retirement/Pension	
Work Comp		Work Comp	
Unemployment		Unemployment	
Child Support		Child Support	
Other		Other	
TOTAL		**TOTAL**	

Combined Liquid Assets Income:

Savings		Cash		Stock/Bonds	
Checking		Trust Acct		Home Equity	
Retirement/ Pension/401K		Credit Union		Other	

Combined Monthly Expense:

House Payment/Rent	Auto Insurance	Life Insurance	Health Insurance
Property Tax	Auto Payment	Childcare	Medical Expenses
Utilities	Food	Other	
Phone/Cell Phone			**TOTAL:**

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ASSIGNMENT OF RIGHTS

By signing below, I declare under penalty of perjury that the information and statements contained in this Application for Financial Assistance and all the documentation which I submit are accurate, true and correct. You are hereby authorized to check my credit history to evaluate this application for Financial Assistance consideration.

I understand that Hoag Hospital may make reasonable requests for additional information and verification if necessary.

I understand that the information and statements I have provided will be kept confidential by Hoag Hospital. I understand that the completion of the application will allow Hoag to consider my circumstances.

I understand Hoag makes no representation that financial assistance is guaranteed.

I/We hereby certify the above information and voluntarily authorize you to obtain credit information relative to me/us.

Signature	Date	Signature	Date

It is important that you complete and submit the completed Financial Assistance Application along with all the required documents within fifteen (15) days.

- Proof of Income: two (2) pay stubs for each wage earner; SS/SSI/SSDI, Public Assistance, Rental Income, Retirement, Pension, VA Benefits, Unemployment, Workers Compensation, Child Support, Alimony or Other
- Copy of your most recent 1040 tax return, including all applicable schedules and attachment.
- Copy of two (2) bank statements (checking/savings). Include all pages.
- Copy of your most recent cancelled rent check, lease agreement or mortgage payment.
- Written statement from a family member or friend who is proving your room and board and/or income.
- If uninsured, eligibility for government-funded programs must be explored. Programs include, but are not limited to: Medicare, Medi-Cal (CA), Covered California, and other state and country funded health coverage programs.

Please send your Financial Assistance Application to:

- **Secure Fax**: 949-764-7031
- **Email:** PFS@hoag.org
- **Mail:** Patient Financial Services
  2975 Red Hill Ave, Suite 200
  Costa Mesa, CA 92626

Once we have reviewed your application, we will notify you of our decision in writing within 30 days of receipt. If you wish to discuss your account or have any questions, please contact us at 949-764-8400. Our business hours are Monday – Friday, 8:30 am to 4:30 pm.