Valley Children's Hospital
9300 Valley Children's Place
Madera, CA 93636
Patient Accounting Department PCX 102

Financial Assistance Application

Please complete the following application and return by mail with the required documentation within 15 days to the address listed above. For assistance completing this application or additional questions please call 559-353-7009.

Please include the following documentation (check all that apply):

1. _____Proof of residences (Utility, Cable or Phone bill)
2. _____Verification of family size (Copy of your most recent income tax return)
3. _____Most recent 1 month of pay stubs or a statement of wages on company letterhead signed by your employer(s)
4. _____Most current bank statement
5. _____Notice of Action from Government sponsored insurance program
6. _____Any other documentation requested to process your Financial Assistance Application.

Patient Information

Patient Name: _____

Patient Account Number(s) _____

_____

Applicant/Guarantor

Relationship to Patient: _____

Name: _____

Address: _____ Cell Phone:_____

City/State/Zip:_____ Home Phone:_____

Co-Applicant/Guarantor

Relationship to Patient: _____

Name: _____ Cell Phone:_____

Family Status: List all dependents that you support (other than self & Co-Applicant)

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient Name: _____

Patient Account Number(s) _____

Employment Information

Applicant/Guarantor

Employer: _____ Position: _____

Contact Person: _____ Phone Number: _____

If Self-Employed,
Name of Business: _____ Phone Number: _____

Co-Applicant/Guarantor:

Employer: _____ Position: _____

Contact Person: _____ Phone Number: _____

If Self-Employed,
Name of Business: _____ Phone Number: _____

Current Monthly Income:

	Applicant/Guarantor	Co-Applicant/Guarantor
Gross Pay (before deductions)	_____	_____
Add		
Income from Operating Business (if Self-Employed)	_____	_____
Other Income		
Interest and Dividends	_____	_____
From Real Estate or Personal Property	_____	_____
Social Security	_____	_____
Spousal/Child Support Received	_____	_____
Other (Specify) _____	_____	_____
Subtract		
Spousal/Child Support Paid	_____	_____
Equals		
Current Monthly Income	_____	_____

Total Current monthly income (add Applicant/Guarantor + Co-Applicant/Guarantor)

_____

Expenses:

Out-of-Pocket Medical Expenses for the last twelve (12) months: _____

(Out-of-Pocket expenses paid by either the Applicant or Co-Applicant on behalf of the patient within the last twelve (12) consecutive months.)

Patient Name: _____

Patient Account Number(s) _____

I certify the above information is true and accurate. I understand that the information submitted may be subject to verification by Valley Children's Hospital and reviewed by Federal and/or State Enforcement Agencies. The undersigned agrees to show proof of this information if so required. Additional information may be requested.

_____ _____

Signature of Applicant/Guarantor Date

_____ _____

Signature of Co-Applicant/Guarantor Date

Valley Children's Hospital granting of Financial Assistance does not apply to professional services provided to Valley Children's patients by physicians or other medical providers including but not limited to Radiology, Anesthesiology, Pathology or Hospitalist services.