Valley Children's HEALTHCARE

9300 Valley Children's Place-Mailstop FP103
Madera, CA 93636
Attn: Patient Financial Services

FINANCIAL ASSISTANCE APPLICATION

Charity Care & Discounted Payment Programs:
This application allows you to apply for both charity care and discounted payment on one form. You will receive the highest level of financial assistance based on the information provided.

How to Apply:

1. **Choose Your Application Method:**
   - **Online:** Apply through *MyChart* for the fastest processing.
   - **Paper Application:** Download this form, fill it out, and submit it via:
     - **Email:** patientfinservices@valleychildrens.org
     - **Mail:** Send it to the hospital's financial services department (address is in the top-right corner of this form).
2. **Gather Required Documents:**
   - **Proof of Income**: (choose one)
     - Most Recent Year Federal Tax Return (both applicant & co-applicant) **OR**
     - Most Recent one-month pay stubs for all employed adults in your household **OR**
     - Award Letter from Unemployment or Disability benefits
3. **Gather Optional Documents:** (not required for processing of application):
     - Letter showing **approval or denial** from Medi-Cal, CCS, Medicare, or other government programs. (**not required** for discounted payment screening but is required for full charity care screening)
     - Hardship Letter: An optional letter to tell us about why you are applying.
4. **Submit Your Application Online, Email or Mail:**
   - Ensure all documents are included to avoid delays.
   - If you need help, call **559-353-7009** or **800-956-2445** (Monday–Friday, 9am–4pm PST).

PATIENT INFORMATION:

Patient Name:	Date of Birth:
Guarantor/Account No:	
Does the patient have medical insurance? ☐YES ☐ NO	
Do you have a Health Savings Account (HSA)? ☐YES ☐ NO	
Has the patient applied for Medi-cal or CCS? ☐YES ☐ NO	

APPLICANT/GUARANTOR:

Marital Status: ☐Single ☐ Married ☐Divorced ☐ Other_____	
Name:	Relationship to Patient:
Address:	
Cell/Phone:	Work Phone:
Employer:	Occupation/Title:

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CO-APPLICANT/GUARANTOR:

Name:	Relationship to Patient:
Address:	
Cell/Phone:	Work Phone:
Employer:	Occupation/Title:

FAMILY SIZE: _____ List all dependents.

Name/Age/Relationship:	Name/Age/Relationship
1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

MEDICAL EXPENSES:

it is optional to submit this information, but it could help you qualify for additional financial assistance

Other medical expenses paid by either the Applicant or Co-applicant on behalf of the patient within the last twelve (12) consecutive months.	**$**

I certify the above information is true and accurate. I understand that the information submitted may be subject to verification by Valley Children's Healthcare and reviewed by Federal and/or State Enforcement Agencies. The undersigned agree to show proof of this information along with additional information that may be requested.

_____ _____ _____

Signature of Applicant/Guarantor Signature of Co-Applicant/Guarantor Date

Valley Children's Hospital Financial Assistance may not apply to professional services provided to Valley Children's patients by physicians or other medical providers, with the exception of Emergency Room physicians.