Hazel Hawkins
MEMORIAL HOSPITAL

Application for Financial Assistance (Free Care)

Thank you for choosing Hazel Hawkins Memorial Hospital as your healthcare provider. This application has been provided to you to determine if you meet the Federal requirement for Financial Assistance (Free Care) at Hazel Hawkins Memorial Hospital. This application must be filled out completely. If we receive an incomplete application, it will be returned and cause a delay to the application processing time. If you have any questions or need help filling out this application, please call the Financial Assistance (Patient Financial Services) Department at **(831) 636-2620.**

Please include with your application the following documents:

- A copy of your Federal Income Tax return for the two (2) most recent years.
- A copy of your Driver's License or State Identification.
- Most recent three (3) months check stubs or a letter from your employer showing proof of your wages.
- If you are self-employed, a copy of your company's Income Statement or Tax Return.
- Written determination of ineligibility for Medi-cal from the Department of Social Services.
- Most recent three (3) month's bank statements.

When determining eligibility for Hospital's Financial Assistance/Free Care, a spouse's income and assets will be used for adults. Parent(s) income and assets will be used for a minor child(ren).

Additional Application Instructions:

1. If the patient is a minor, the guarantor or guardian must provide his/her information.
2. If the patient is deceased, the executor of the estate or the legal guardian must provide his/her information or a death certificate.
3. One application per patient.
4. The application is good for a period of three (3) months in the current year from date of service.
5. If you are unemployed and live with someone, please provide a letter from the person showing proof of support.
6. If you are unemployed, please provide copy of your unemployment compensation warrant.
7. Completed application must be returned to us within fourteen (14) days of issue.

Section 1 – Personal Information Today's Date _____/_____/_____

Date of Service _____

_____

Patient Name (Last, First, MI) Social Security Number (Optional)

_____

Street Address of Patient City, State, Zip Code

Patient Date of Birth: ___/___/_____

Telephone #: (____) _____

Name of Guarantor (If other than patient):_____

Family Size: _____

Names Age Relationship

_____
_____
_____
_____

_____

Employer/Company Name Job Title Length of Employment

_____

Employer's Name Contact Person Telephone # Number

_____

Street Address City/State/Zip

_____

Does your employer offer medical coverage Yes/No (Circle one) If yes, reason why you are not covered? _____

Section 2- Source of income		**Weekly**	**Monthly**	**Yearly**
Salary before deductions (Including Military)	$_____	☐	☐	☐
Public Assistance	$_____	☐	☐	☐
Social Security (and/or VA benefits)	$_____	☐	☐	☐
Alimony/Child Support	$_____	☐	☐	☐
Pension Payments/Dividends and Interest	$_____	☐	☐	☐
Rental/Real Estate income	$_____	☐	☐	☐
Other Monetary Support	$_____	☐	☐	☐

Grand Total of Income: _____

Section 3 – Certification by Applicant

I, _____, understand that the information that I submit is subject to verification by Hazel Hawkins Memorial Hospital, its employees, and the Federal/State government. Intentional misrepresentation of these facts will make me liable for all hospital charges and subject to civil penalties. As requested by Hazel Hawkins Memorial Hospital, I certify that I have applied for Medi-Cal through the State of California and have attached with this application a copy of the denial letter. I certify that the above information regarding my family size, income, and assets is true and correct. I understand that it is my responsibility to advise Hazel Hawkins Memorial Hospital of any changes in status in regards to my income or assets while this application is in process.

_____ _____

Signature of Applicant (Patient or Guarantor) Date

Please attach copies of all proof of income and assets with this application.