



### **Financial Assistance Application Instructions**

If you do not have insurance coverage, you may be eligible for charity care or other hospital discount. Any individual, whose family income is at or below 400% of the Federal Poverty Level, may be eligible for discounted services under the hospital's charity care policy. In addition, patients without insurance coverage may be eligible for government programs such as Medi-Cal and other government funded healthcare assistance programs. Or you are welcome to obtain applications for coverage offered through the California Health Benefit Exchange: [www.coveredca.com](http://www.coveredca.com) or through the Stanislaus County Community Service Agency at (877)652-0734 or <http://www.csa-stanislaus.com>

1. Please complete all areas on the attached application form. If any area does not apply to you, please write N/A (not applicable) in the space provided.
2. Attach an additional page if you need more space to answer a question.
3. You must provide proof of denied government assistance programs.
4. You must provide proof of income when submitting this application. The following documents are accepted as proof of income:

**If you filed a federal income tax return, you must submit a copy of:**

- a. Prior year Federal Income Tax Return (ex. form 1040) and should include all schedules and attachments, as submitted to the Internal Revenue Service (IRS); **TAXES AND LETTER OF EXPLANATION.**

**If you did not file a federal income tax return, please provide the following:**

- a. Two (2) most recent paycheck stubs; and
- b. A letter explaining why you do not file a federal income tax return, and
- c. Two months of current bank statements for checking and saving accounts

**If you have no income, please provide a letter explaining how you support yourself/family.**

5. You must provide proof of monetary assets, such as two (2) current bank statements and the documents that indicate amounts owned by the patient or family representative.
6. Your application cannot be processed until all required information is provided. It is important that you complete and submit the financial assistance application along with all required documentation within 14 days.
7. You must sign and date the application. If the patient/guarantor and spouse provide information, both must sign the application.
8. If you have questions, please call your account representative at 209-848-5366
9. Send your completed application to:

Oak Valley Hospital District  
Attn: Patient Financial Services Department – Financial  
Assistance 350 South Oak Ave. Oakdale, Ca.95361 Fax  
209-848-7008

**PATIENT FINANCIAL ASSISTANCE APPLICATION**

**ACCOUNT/MEDICAL RECORD#:** \_\_\_\_\_

RESPONSIBLE PARTY NAME: LAST			FIRST	MIDDLE
PATIENT NAME IF OTHER THAN RESPONSIBLE PARTY:			SOCIAL SECURITY #:	
ADDRESS:			PHONE:	
CITY, STATE & ZIP:			WORK/CELL PHONE:	
EMPLOYER:	CONTACT PERSON/PHONE #		OCCUPATION:	

**SPOUSE INFORMATION**

NAME: LAST			FIRST	M.I.	SOCIAL SECURITY #:
ADDRESS:			PHONE:		
CITY, STATE & ZIP:			WORK/CELL PHONE:		
EMPLOYER:	CONTACT PERSON/PHONE #:		OCCUPATION:		

**LIST ALL DEPENDENTS**

NAME	RELATIONSHIP	AGE

**MONTHLY INCOME**

	PATIENT/RESPONSIBLE PARTY	SPOUSE
<b>GROSS WAGES (before deductions)</b>		
<b>OTHER INCOME:</b>		
INTEREST & DIVIDENDS		
REAL ESTATE RENTAL/LEASE		
SOCIAL SECURITY		
UNEMPLOYMENT/DISABILITY		
ALIMONY/CHILD SUPPORT		
OTHER (attach details)		

MONTHLY EXPENSES		
RENT/MORTGAGE		
ALIMONY/CHILD SUPPORT		
FOOD/SUPPLIES		
CHILDCARE/SCHOOL		
UTILITIES (Gas, electric, water, phone etc.)		
INSURANCE PREMIUMS (Medical, home, auto)		
AUTO PAYMENTS		
TRANSPORTATION EXPENSES (fuel, repair costs)		
CREDIT CARD/PERSONAL LOAN PAYMENTS		
CURRENT MEDICAL PAYMENTS		
OTHER (provide description)		
OTHER (provide description)		
ASSETS		
CASH ON HAND		
CHECKING ACCOUNT*		
SAVINGS ACCOUNT*		
REAL ESTATE EQUITY		
MOTOR VEHICLE OWNED; YEAR/MAKE/MODEL	VALUE	
MOTOR VEHICLE OWNED; YEAR/MAKE/MODEL	VALUE	
RV/BOAT/MOTORCYCLE/MOTORHOME YEAR/MAKE/MODEL	VALUE	
TRUST ACCOUNTS		
OTHER SOURCES (STOCKS,BONDS)		
*BANK BRANCH(S) & ACCOUNT NUMBERS		

*\*Please provide two (2) months of the most current bank statements, as well as branch name and account numbers.*

**By signing below, I/We declare that all information provided is true and correct to the best of my/our knowledge. I/We authorize Oak Valley Hospital to verify any information listed in this application. We expressly grant permission to contact my/our employer.**

**Patient Signature** \_\_\_\_\_

**Date** \_\_\_\_\_

**Spouse Signature** \_\_\_\_\_

**Date** \_\_\_\_\_

**Parent/Guardian** \_\_\_\_\_

**Date** \_\_\_\_\_