FINANCIAL ASSISTANCE

Hoag Hospital is dedicated to providing quality health care to our patients. We realize that payment of those services many be a financial hardship for you at this time. Hoag Hospital offers Financial Assistance to aid those that may qualify to reduce or eliminate their cost of care obligation.

Attached with this letter, you will find an application to enable an evaluation of your financial hardship. You must complete the application in order to be considered for the financial assistance program. If your financial situation meets the eligibility criteria set forth by the Hoag Financial Assistance Program, you may be eligible for full or partial forgiveness of debt.

In order to process this application we require:

- The enclosed application completed in its entirety
- You must sign and date the Financial Assistance Application. If the patient/guarantor and/or spouse provide information, both must sign the application.
- Copy of your most recent cancelled rent check, lease agreement or mortgage payment
- Copy of the last two (2) pay stubs for any wage earned contributing to the household income
- Copy bank statements (checking/savings)
- Copy of your disability, social security payment statement, unemployment notice of eligible benefits and bank statement reflecting deposits
- If you do not have a source of income or proof of income documents, please provide a letter explaining how you support yourself and your family.
- Written, signed statement from a family member or friend who is proving your room and board and/or income.
- Copy of your most recent 1040 tax return or W2, including all applicable schedules and attachments submitted to the Internal Revenue Service
- If your most recent 1040 tax return is not available, then we will need one of the following:
    - Social Security Awards Letter
    - Proof of non-filing from the IRS (call 800-829-1040 to obtain a copy)
    - A signed letter explaining why you have not filed a federal tax return or have requested an extension for taxes.
- Attach an additional page if you need more space to answer any questions

We realize that your income from previous tax records may not adequately reflect your current circumstances. If so, please attach a brief note that describes your current financial situation.

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

- **Secure Fax**: 949-764-7246

- **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.

FINANCIAL ASSISTANCE APPLICATION

Demographic Information

Name	Date of Birth	Spouse/Partner	Date of Birth	
ADDRESS		City	State	Zip
Time at Present Address ____Rent ____Own _____Years _____Months		County	Marital Status __Married __Single __Divorced __Widowed	
Cell Number	Work 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	Frist 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: __Years __Months __ Hours Worked Per Week		Length Employed: __Years __Months __ Hours Worked Per Week	

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

Source of Income

	Self Monthly Gross		Spouse Monthly Gross
Gross Income		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 Monthly Gross Income:	

Assets/Property

Checking		Cash On Hand		Retirement Plan	
Savings		Trust Account		Home Equity	
Stock/Bonds		Credit Union		Other	

Monthly Expense

House Payment/Rent	Auto Insurance	Life Insurance	Health Insurance
Property Tax	Phone/Cell Phone	Food	Water and Sewer
Property Insurance	Vehicle Payment	Daycare Expense	Medical Expenses
Gas	Vehicle Payment	Child Support Expense	Other/Specify:
Electric			**TOTAL**

REQUIRED DOCUMENTS:

___ Proof of Income (i.e. 2 Pay stubs for each wage earner, SS,SSI,SSDI, Public Assistance, Rental Income, Retirement, Pension, VA Benefits, Unemployment, Workers Comp, Child Support, Alimony or Other)

___ Copy of your most recent 1040 tax return, including all applicable schedules and attachments

___ Copy of two (2) bank statements (checking/savings) 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.

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 in order to evaluate this application for Financial Assistance consideration.

I understand that Hoag Hospital may make reasonable requested for additional information and verification is 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