

FINANCIAL ASSISTANCE APPLICATION INSTRUCTIONS

- 1. Please complete **all** areas on the attached application form. If any area does not apply to you, write N/A in the space provided.
- 2. Attach an additional page if you need more space to answer any question.
- 3. You must provide proof of income documents when you submit 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. Federal income tax return (Form 1040) from the most recent year. You must include all schedules and attachments as submitted to the Internal Revenue Service.

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

a. Two (2) most recent paycheck stubs.

If you have no income, or proof of income documents, we request that you please provide a letter explaining how you support yourself/family.

- 4. Your application for assistance cannot be processed until all required information is provided.
- 5. It is important that you complete and submit the Financial Assistance Application along with all required attachments as soon as possible so that LLUCH may determine your eligibility. Eligibility may be determined at any time LLUCH is in receipt of documentation.
- 6. You must sign and date the Financial Assistance Application. If the patient/responsible party and spouse provide information, both must sign the application.
- 7. If you have questions, please call the Patient Business Office at (909) 651-4177, between the hours of 9:00 a.m. and 5:00 p.m. Monday through Thursday, and 9:00 a.m. to 2:00 p.m. on Friday (excluding weekends and holidays). Weekends, holidays and after hours, please contact any Registration Representative for assistance.
- 8. Send your completed Financial Assistance Application and all required documents to:

Loma Linda University Children's Hospital Patient Business Office P. O. Box 907 Loma Linda, CA 92354



Loma Linda University Children's Hospital

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PATIENT IDENTIFICATION

19-0332C (7-24)

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The purpose of this form is to determine patient/responsible party eligibility for financial assistance in accordance with the Loma Linda University Children's Hospital Charity Care/Discount Payment Policy.

PATIENT/RESPONSIBLE PARTY NAME	SPOUSE NAME		
ADDRESS	PHONE Home: Work:		
SOCIAL SECURITY NUMBER Patient/Responsible party	Spouse		
FAMILY STATUS (List all dependents that you s	upport)		
Name	Age	Relationship	
EMPLOYMENT STATUS Patient/Responsible party			
Employer			
Patient/Responsible party			
Position			
Employer			
Contact			
Person			
Employer Contact			
Telephone			
Spouse Employer			
Spouse			
Position			
Employer			
Contact			
Person			
Employer Contact			
Telephone			

LOMA LINDA UNIVERSITY CHILDREN'S Loma Linda University Children's Hospital

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PATIENT IDENTIFICATION

INCOME	Pati	ent/Guarantor	Spouse	
1. Gross Wages & Salary/Year (before deductions) \$			\$	
2. Self-Employment Income/Year	\$		\$	
3. Other Income:				
a. Interest & Dividends	\$		\$	
b. Real Estate Rentals & Leases	\$		\$	
c. Social Security	\$		\$	
d. Alimony	\$		\$	
e. Child Support	\$		\$	
f. Unemployment/Disability	\$		\$	
g. Public Assistance	\$		\$	
h. All Other Sources (attach list)	\$		\$	
Total Income (add lines 1 - 3h above)	\$		\$	
Total income (add lines 1 - 311 above)	Ψ		Ψ	
UNUSUAL EXPENSES Please provide information on any unusual expenses significant judgments or settlement payments (attach list as need)		ical bills, bankru	ıptcy, court	
Description		Aı	Amount	
By signing below, I/we declare that all information proknowledge. I/we authorize LLUCH to verify any informat permission to contact my/ our employer.			•	
Signature of Patient/Responsible party	Relation	Relationship to Patient Date		
Signature of Spouse	Date	Date		
Loma Linda University Children's Hospital	PATIENT	IDENTIFICATION		
LOMA LINDA FINANCIAL ASSISTANCE UNIVERSITY				

CHILDREN'S HOSPITAL

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