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; and
   b. A letter explaining why you do not file a federal income tax return.

   **If you have no income, or proof of income documents, 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 within **fourteen (14) days.**

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
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.

<table>
<thead>
<tr>
<th>PATIENT/RESPONSIBLE PARTY</th>
<th>SPOUSE</th>
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<tbody>
<tr>
<td>NAME _____________________</td>
<td>NAME</td>
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ADDRESS
_______________________________________
_______________________________________

SPOUSE
PHONE
Home: _______________________
Work: _______________________

SOCIAL SECURITY NUMBER
Patient/Responsible party __________
Spouse _______________________

FAMILY STATUS (List all dependents that you support)

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Relationship</th>
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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 Hospital

FINANCIAL ASSISTANCE
APPLICATION INSTRUCTIONS
Page 2 of 3
INCOME

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) $  

UNUSUAL EXPENSES

Please provide information on any unusual expenses such as medical bills, bankruptcy, court judgments or settlement payments (attach list as needed).

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
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By signing below, I/we declare that all information provided is true and correct to the best of my/our knowledge. I/we authorize LLUCH to verify any information listed in this application. I/we expressly grant permission to contact my/our employer.

_______________________________________________________________  
Signature of Patient/Responsible party  Relationship to Patient  Date  

_______________________________________________________________  
Signature of Spouse  Date