

ATTACHMENT B

Pioneers Memorial Hospital 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. Please note that based on eligibility, discount payment offers less financial assistance than charity care.
3. Attach an additional page if you need more space to answer any question.
4. 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 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. Three (3) recent paycheck stubs; and

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

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5. Your application cannot be processed until *all* required information is provided.
6. It is important that you complete and submit the financial assistance application along with all required attachments.
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 financial counselors at (760) 351-3322 and (760) 351-3323.
9. Send your completed application to:
Pioneers Memorial Hospital
Patient Financial Services Department
207 West Legion Road
Brawley, CA 92227

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Pioneers Memorial Hospital

Financial Assistance Application

PATIENT/ GUARANTOR NAME		SPOUSE NAME	
ADDRESS		PHONE	
		Home	
		Work	
SOCIAL SECURITY NUMBER (optional)			
Patient/ Guarantor		Spouse	

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FAMILY STATUS

List all dependents that you support

Name	Age	Relationship
EMPLOYMENT STATUS (optional)		
Patient/Guarantor Employer	Position	
Contact Person	Telephone	

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Spouse Employer	Position
Contact Person	Telephone

INCOME		
	Patient/Guarantor	Spouse
1. Gross Wages & Salary/Year (before deductions)		
2. Self-Employment Income/Year		
3. Other Income:		
3. Interest & Dividends		
4. Real Estate Rentals & Leases		
5. Social Security		

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6. Alimony		
7. Child Support		
8. Unemployment/Disability		
9. Public Assistance		
10. All Other Sources (attach list)		
Total Income (add lines 1 - 10 above)		

UNUSUAL EXPENSES (optional)

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

Description	Amount

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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 Pioneers Memorial Healthcare District to verify any information listed in this application. We expressly grant permission to contact my/our employer.

Signature of Patient/Guarantor

Signature of Spouse

Date
