MemorialCare

Long Beach Medical Center
Miller Children's & Women's Hospital Long Beach
Orange Coast Medical Center
Saddleback Medical Center

Financial Assistance Application

ACCOUNT NUMBER(S): _____

Step 1: Tell us about yourself and your family

Guarantor		Spouse	
Address:		Phone #:	
Social Security number: Guarantor: _____ Spouse: _____			
If you are a recipient of any low-income government-funded assistance or program. Please check here ☐			

List all dependents that you support.		
Name	**Age**	**Relationship**

Step 2: Tell us about your income

Note: For patients applying only for discount payment program eligibility, we may only request recent paystubs or income tax returns for documentation of income. We may accept other forms of documentation of income but shall not require such other forms.

	Guarantor Employer	Spouse Employer
Employer	Name: _____ Phone number: _____	Name: _____ Phone number: _____
1. Gross Wages & Salary (before deductions)*	$	$
*Include 2 recent consecutive paycheck stubs. If not available, then last Filed Federal income tax return as submitted to the Internal Revenue Service. *If you are paid in cash or are self-employed, submit a written statement explaining your income sources. *If your income is $0, submit a written statement explaining how you support yourself.		
Other Income:		
2. Interests & Dividends	$	$
3. Real Estate Rentals & Leases	$	$
4. Social Security* • *Include copy of award letter	$	$
5. Unemployment/Disability	$	$
6. All Other Sources	$	$

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Step 3: Tell us about your Assets if you are applying for Charity Care, otherwise go to Step 4

Note: Patients who only apply for discount payment program eligibility may receive less financial assistance than what may be available to them under the charity care program.

Assets	Estimated Value	Amount Owed
1. Primary Residence and/or other real estate (attach list)	$	$
2. Motor Vehicles (attach list)	$	$
3. Bank Accounts & Investments* • *Include bank statements showing deposits and credits	$	$
4. Other Assets (attach list)	$	$

Step 4: Please read and sign this application

By signing below, I/We declare that all information provided is true and correct to the best of my/our knowledge. I/We authorize MemorialCare to verify any information in this application. I/We expressly grant permission to contact my/our employer, banking, and lending institutions. In addition, my/our credit report may be obtained. I understand that Financial Assistance programs are a "Payor of Last Resort" and hereby assign to the facility all benefits due from any liability action, personal injury claims, settlements and any and all insurance benefits which may become payable, for illness or injury for which the facility or it's subsidiaries provided care.

_____ _____ _____ _____

Signature of Patient/Guarantor Date Signature of Spouse Date

Step 5: Reminders

Did you…

☐ complete all areas and write N/A if any area does not apply to you?
☐ attach an additional page if you need more space to answer any question?
☐ and your spouse, if married, complete and sign?
☐ include *all* required information and copy of attachments?

☐ Proof of Income
- ☐ 2 recent consecutive paycheck stubs
- ☐ Copy of Social Security award letter
- ☐ If paid cash or Self-Employed submit a written statement explaining your income sources
- ☐ If not available then last filed Federal income tax return

☐ Assets
- ☐ Submit 2 recent consecutive Bank statements showing deposits and credits

When ready to submit, please send the application with the required documents to:

▶ MemorialCare, ATTN: FAA, P.O. Box 20894, Fountain Valley, CA 92728-0894 or

Email: pfsdocuments@memorialcare.org. If you have any questions, please call us at 1-877-323-0043.