

**St. Joseph Health System
Financial Assistance Application**

INSTRUCTION

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 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;
- b. Federal W-2 Form showing wages and earnings;

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

- a. Two (2) most recent paycheck stubs; and
- b. Two (2) most recent stubs from any Social Security, child support, unemployment, disability, alimony, or other payments;
- c. Two (2) consecutive bank statements.
- d. If you are paid only in cash, please provide a written statement explaining your income sources;
- e. A letter explaining why you do not file a federal income tax return.

If you have no income, please provide a letter explaining how you support yourself/family.

4. Your application 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 ten (10) days.
6. You *must* sign and date the application. If the patient/guarantor and spouse provide information, both *must* sign the application.
7. If you have questions, please call your account representative. (949) 347-6046
8. Send your completed application to:

Mission Hospital
Patient Financial Services Department
27700 Medical Center Road, MOB 3 Suite 465
Mission Viejo, CA 92691

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ACCOUNT NUMBER			
PATIENT/ GUARANTOR NAME		SPOUSE NAME	
ADDRESS		PHONE	
		Home	
		Work	
		Cell	
SOCIAL SECURITY NUMBER			
Patient/ Guarantor		Spouse	
FAMILY STATUS: List all dependents that you support (additional space available on page 4)			
Name		Date of Birth	Relationship
EMPLOYMENT STATUS			
Patient/Guarantor Employer	Position		
Contact Person	Telephone		
Spouse Employer	Position		

Contact Person	Telephone		
INCOME			
	Patient/Guarantor	Spouse	
1. Gross Wages & Salary (before deductions)			
2. Self-Employment Income			
3. Interest & Dividends			
4. Real Estate Rentals & Leases			
5. Social Security			
6. Alimony			
7. Child Support			
8. Unemployment/Disability			
9. Public Assistance			
10. All Other Sources (attach list)			
Total Income (add lines 1 - 10 above)			
QUALIFIED MONETARY ASSETS			
	Patient / Guarantor	Spouse	Total
1. Checking Account(s) Balanc			
2. Savigs Account(s) Balance			
3. Stock, Bonds, CDs Value			
4. Other _____			
5. Other _____			
Qualified Monetary Assets (total lines 1-5)			
UNUSUAL EXPENSES			
Please provide information on any unusual expenses such as medical bills, bankruptcy, court judgments or settlement payments (additional space available on page 4 - attach list as needed).			

MISSION VIEJO • LAGUNA BEACH

Description	Amount

The undersigned declares that all information provided is true and correct to the best of his/her knowledge. The undersigned authorizes Mission Hospital to verify any information listed in this application. The undersigned expressly grants permission to contact his/her employer, banking and lending institutions, and to check his/her credit history.

Signature of Patient/Guarantor

Signature of Spouse

Date

Date

St. Joseph Health System Mission Statement: “To extend the Catholic health care ministry of the sisters of St. Joseph of Orange, by continually improving the health and quality of life of people in the communities we serve”.

*Dignity • Service • Excellence •
Justice*

