Valley Children's HEALTHCARE

Patient Name: _____ DOB: _____

Medical Record #_____

9300 Valley Children's Place-Mailstop FP103
Madera, CA 93636
Attn: Patient Financial Services

Thank you for your interest in the Financial Assistance Program. Please complete the following application and return copies of the required documentation as soon as possible. Applications can be uploaded via MyChart, emailed to patientfinservices@valleychildrens.org or mailed to address above. For additional questions please call 559-353-7009 or 800-956-2445 Monday- Friday from 9am-4pm.

THE FOLLOWING DOCUMENTS ARE REQUIRED:

	One of the Following: 1) Federal Tax Return: Most recent tax return; Please include all pages OR, if a tax return is not available, 2) Paycheck Stubs: Most recent one (1) month of pay stubs from all employed adults in the family, statement of wages on company letterhead, or award letter from unemployment/disability
	Hardship Letter
	For charity care screening only (does not apply to discount payment screening): Notice of Action from Government Sponsored Insurance Program - Denial or Approval notice from Medi-Cal, CCS, Medicare, or another identified program

PATIENT INFORMATION:

Patient Name:	Date of Birth:	
Account Number/s:		
Does the patient have medical insurance?	YES	NO
Has the patient applied for Medi-cal or CCS?	YES	NO

APPLICANT/GUARANTOR:	CO-APPLICANT/GUARANTOR
Relationship to Patient:	Relationship to Patient:
Name:	Name:
Address:	Address:
City/ State/Zip:	City/State/Zip:
Cell/Phone:	Cell/Phone:
EMPLOYER:	EMPLOYER:
Business Name (if Self-Employed)	Business Name (if Self-Employed)
Occupation/Title:	Occupation/Title:
Work Phone:	Work Phone:

FAMILY SIZE: _____ List all dependents in the family.

Name:	Age/Relationship:	Name:	Age/Relationship:
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

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DISCLOSURE OF ESSENTIAL LIVING EXPENSES:

EXPENSES:		COMMENTS
Donations	$	
Savings	$	
Spousal/Child Support Paid/Other	$	
Rent/Mortgage Payment	$	
Utilities	$	
Food	$	
Transportation	$	
Insurance	$	
Medical	$	
Clothing	$	
Entertainment	$	
Revolving Account/s	$	
Car Payment/s	$	
List all other expenses:		
TOTAL EXPENSES	$	

Do you have a Health Savings Account (HSA)? ☐YES ☐ NO

MEDICAL EXPENSES:

Out-of-pocket expenses paid by either the Applicant or Co-applicant on behalf of the patient within the last twelve (12) consecutive months.	**$**

I certify the above information is true and accurate. I understand that the information submitted may be subject to verification by Valley Children's Healthcare and reviewed by Federal and/or State Enforcement Agencies. The undersigned agree to show proof of this information along with additional information that may be requested..

_____ _____

Signature of Applicant/Guarantor Signature of Co-Applicant/Guarantor Date

Valley Children's Healthcare granting Financial Assistance does not apply to professional services provided to Valley Children's patients by physicians or other medical providers, with the exception of Emergency Room physicians.