BeverlyHospital

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. 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:

   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;
   c. Two (2) most recent paycheck stubs.

   If you did not file a Federal Income Tax Return, or if financial information has changed since your Income Tax Return was filed, please provide the following:

   a. Two (2) most recent paycheck stubs;
   b. Two (2) most recent check 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.

   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, sign and submit the Financial Assistance Application along with all required attachments within fourteen (14) 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.
8. Send your completed application to:

   Beverly Hospital
   Patient Financial Services Department
   309 West Beverly Blvd.
   Montebello, CA 90640-4308

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Financial Assistance Application

PATIENT/ GUARANTOR NAME		**SPOUSE NAME**	
ADDRESS		**PHONE**	
		HOME	
		WORK	
SOCIAL SECURITY NUMBER			
PATIENT/ GUARANTOR NAME		**SPOUSE NAME**	
FAMILY STATUS **List all dependents that you support**			

Name	Age	Relationship

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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		
Other Income:		
3. Interest & Dividends		
4. Real Estate Rental & 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)		

Expenses for rent or house payment and maintenance, food and household supplies, utilities and telephone, clothing, medical and dental payments, insurance, school or child care, child or spousal support, transportation and auto expenses (including insurance, gas and repairs), installment payments, laundry and cleaning expenses

EXPENSES	**Amount**
1. Rent of house payment and maintenance	
2. Food and household supplies	
3. Utilities and telephone	
4. Clothing	
5. Medical and Dental payments	
6. Insurance	
7. School or child care	
8. Child or spousal support	
9. Transportation and auto expenses (including insurance, gas and repairs)	
10. Installment payments	
11. Laundry and cleaning expenses	
Total Expenses (Add Lines 1-11 Above)	

EXTRA ORDINARY EXPENSES	
Please provide information on any extra ordinary expenses such as medical bills.	
Description	**Amount**

ASSETS		
Please provide an accurate estimate of value for each asset you own. Also, indicate how much you owe on any outstanding debt related to each asset listed.		
Asset	**Value**	**Amount Owed**
1. Primary Residence		
2. Other Real Estate (Attach List)		
3. Motor Vehicle (Attach List)		
4. Other Personal Property		
5. Bank Account & Investments		
6. Retirement Plan		
7. Other Assets (Attach List)		
Total Amounts (Add Lines 1 – 7 Above)		

By signing below, I/we declare that all information provided is true and correct to the best of my/our knowledge. I/we authorize Beverly Hospital to verify any information listed in this application. We expressly grant permission to contact my/our employer, banking and lending institutions, and to check my/our client credit history.

Signature of Patient/Guarantor	**Signature of Spouse**
Date	**Date**

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Financial Assistance Programs

Beverly Hospital offers Financial Assistance Programs to assist patients who may be uninsured. To obtain information and/or a Financial Assistance Program Application, please contact (323) 725-4347.

Programas de Asistencia Financiera

Beverly Hospital ofrece Programas de Asistencia Financiera para asistir a pacientes que no tienen seguro medico. Para obtener información o una Aplicación de Asistencia Financiera, por favor llamar a servicios financieros al: (323) 725-4347.