Patient Name: _____ DOB: _____

Medical Record #_____

Valley Children's HEALTHCARE

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 with copies of the required documentation within 15 days.
Applications can be uploaded via MyChart, mailed to the address above or emailed to patientfinservices@valleychildrens.org. For assistance completing this application or additional questions please call 559-353-7009 or 800-956-2445 Monday- Friday from 9am-4pm.

Please include the following documentation with your completed application:

	Proof of residence (Utility, Cable, or Phone Bill)
	Verification of Family Size (Copy of most recent income tax return-all pages)
	Recent one (1) month of pay stubs from all employed adults, statement of wages on company letterhead, or award letter from unemployment/disability
	Current Bank Statement (Checking & Savings- all pages)
	Notice of Action from Government Sponsored Insurance Program
	Hardship Letter
	Any other documentation requested to process your Financial Assistance application

PATIENT INFORMATION:

Patient Name:	Date of Birth:
Account Number/s:	

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

FAMILY SIZE: #_____

List all dependents that you support ,other than Self or Co- Applicant

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

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INCOME & EXPENSES STATEMENT

INCOME: List all income	**Applicant/Guarantor**	**Co-Applicant/Guarantor**
Gross Pay (before deductions)	$	$
Income from Operating Business (if Self Employed)	$	$
Interest and Dividends	$	$
From Real Estate or Personal Property	$	$
Social Security	$	$
Spousal/Child Support Received	$	$
Other Income (Specify):	$	$
Add Income from all Sources	$	$
TOTAL INCOME COMBINED	$	
EXPENSES FOR DONATION/SAVINGS		**COMMENTS**
Donations	$	
Savings	$	
Spousal/Child Support Paid/Other	$	
LIVING EXPENSES		
Rent/Mortgage Payment	$	
Utilities	$	
Food	$	
Transportation	$	
Insurance	$	
Medical	$	
Clothing	$	
Entertainment	$	
Revolving Account/s	$	
Car Payment/s	$	
List all other expenses:		
TOTAL EXPENSES	$	
AVAILABLE INCOME	$	Subtract Expenses from Income

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 agrees to show proof of this information if so required. Additional information may be requested.

_____ _____ _____

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

Valley Children's Healthcare granting of Financial Assistance does not apply to professional services provided to Valley Children's patients by physicians or other medical providers including but not limited to Radiology, Anesthesiology, Pathology or Hospitalist services.