Antelope Valley Medical Center
1600 West Avenue J • Lancaster, CA 93534 • (661) 949-5000
www.avmc.org

FINANCIAL ASSISTANCE APPLICATION

Please complete ***all*** areas on the application form, and return within 14 days. If any area does not apply to you, write N/A in the space provided. You ***must*** provide proof of income documents 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;

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

a. Two (2) most recent paycheck stubs

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

If you have any questions, please call the Business Office at (661) 949-5781 or (800) 403-1857

Hospital Account Number(s)	
Patient/Guarantor Name	
Spouse Name	
Address (Street)	
Address (City, State, Zip)	
Home Phone	( ) **Work Phone** ( ) **Cellular Phone** ( )
Patient/Guarantor SSN	
Spouse SSN	

FAMILY STATUS List all dependents that you support		
Name	**Age**	**Relationship**

EMPLOYMENT STATUS		
	Patient/Guarantor	**Spouse**
Employer Name		
Position		

MONTHLY INCOME		
	Patient/Guarantor	**Spouse**
1. Gross Wages & Salary/Month		
2. Self-Employment Income/Month		
3. Social Security		
4. Child Support		
5. Unemployment/Disability		
6. Public Assistance		
7. All Other Sources (attach list)		

By signing below, I/we declare that all information provided is true and correct to the best of my/our knowledge. I/we authorize Antelope Valley Medical Center to verify any information listed in this application. We expressly grant permission to contact my/our employer.

_____
Signature of Patient/Guarantor

_____
Signature of Spouse

_____
Date

_____
Date