



Financial Assistance Application

Antelope Valley Medical Center's Financial Assistance Program provides financial assistance to patients with medically necessary healthcare needs with low-income, uninsured or underinsured, ineligible for a government program, and is otherwise unable to pay for medically necessary care based on their individual family financial situation. Those who apply for discounted payment may receive less financial assistance than those who apply for charity care. To determine if a patient/guarantor qualifies for financial assistance, we need to obtain certain financial information. Your cooperation will allow us to give all due consideration to your request for financial assistance.

Name _____ Address _____
Date of Birth ___/___/___ Social Security _____ Phone number _____
Financial Account Number(s) _____

List Dependents:

Table with 3 columns: Name, Relationship, Age. Includes horizontal lines for data entry.

Number of dependents filed on tax return: _____

Table with 3 columns: Wages/Income, Monthly, Annual. Rows include Self-Wages, Spouse/Domestic Partner Wages, Other Family Member Wages, Social Security/Disability Benefits, Military Family Allotments, Retirement/Pensions, Unemployment Benefits, Alimony/Child Support, Income from Rent, Dividends, Interest.

Table with 3 columns: Expenses, Monthly, Annual. Rows include Mortgage/Rent, Utilities, Auto Loans, Medical Bills, Phone/Internet, Food/Gas, Credit Cards, Child Care/Other.

Please submit tax returns dated during 12 months and 4 paystubs within 6 months of the first bill date.

My signature attests that the information I have provided on this form is accurate and true to the best of my knowledge.

Print Applicant Name Applicant Signature Date