



Pacifica Hospital of the Valley  
Financial Assistance Application Form Instructions

This is an application for financial assistance at Pacifica Hospital of the Valley.

Pacifica Hospital of the Valley provides financial assistance to people and families who meet certain income requirements. You may qualify for free care or discounted care based on your family size and income, even if you have health insurance. Assistance is provided for those patients whose family income is lower than 500% of the Federal Poverty Level Guidelines. Information on the Federal Poverty Level Guidelines can be found at <http://aspe.hhs.gov/poverty-guidelines>.

What does financial assistance cover? The hospital financial assistance covers appropriate hospital-based services provided by Pacifica Hospital of the Valley depending upon your eligibility. Financial assistance may not cover all health care costs, including services provided by other organizations. If you have questions or need help completing this application: You may obtain help for any reason, including disability and language assistance at: 818.252.2196

For your application to be processed, you must:

- Provide us information about your family
- Provide us information about your family's gross monthly income (income before taxes and deductions)
- Provide documentation for family income
- Provide documentation for family assets
- Attach additional information if needed
- Sign and date the form

Note: You do not have to provide a Social Security number to apply for financial assistance. If you provide us with your Social Security number, it will help speed up processing of your application. Social Security numbers are used to verify information provided to us. If you do not have a Social Security number, please mark "not applicable" or "NA."

Mail or fax completed application with all documentation to:

Pacifica Hospital of the Valley, 9449 San Fernando Rd, Sun Valley CA 91352, Fax: 818.252.2354

Be sure to keep a copy for yourself.

To submit your completed application in person: Pacifica Hospital of the Valley, 9449 San Fernando Rd. Sun Valley CA, 91352. We will notify you of the final determination of eligibility and appeal rights, if applicable, within 30 calendar days of receiving a complete financial assistance application, including documentation of income. By submitting a financial assistance application, you give your consent for us to make necessary inquiries to confirm financial obligations and information. We want to help. Please submit your application promptly!

You may receive bills until we receive your information.

**PHV Confidential Medical and Financial Assistance Application**

Facility:	Acct. #:	Patient Name:	SSN:	DOB:
Patient Address:				
Patient Home Phone:		Patient Work Phone:		

**SECTION A**

**MEDICAL ASSISTANCE SCREENING**– Please check answer “Y” for yes to “N” for no.

**Y/N**

1. Is the patient under age 21 or over age 65?	/	5. Is the patient pregnant, or was the admission pregnancy related?	/
2. Is the patient a single parent of a child under age 21?	/	6. Will the patient potentially be disabled for 12 months or more?	/
3. Is the patient a caretaker or guardian of a child under 21?	/	7. Is the patient a Victim of Crime?	/
4. Is the patient a married parent of a minor child? <i>If yes, does the patient have a 30-day incapacitation?</i>	/	8. Does the patient have a “COBRA” or other insurance policy for which the premium has lapsed?	/

**SECTION B**

To determine qualifications for any discounts or assistance programs the following information is necessary.

**RESPONSIBLE PARTY/GUARANTOR**

Responsible Party:		Relationship to patient:	
SSN:	DOB:		
Home Address:		Phone #:	
Work Address:		Phone #:	
Gross Income:	Circle One - <input type="checkbox"/> Hourly <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly		
Hours Per Week:			
If income is \$0/unemployed, what is your means of support?	<input type="checkbox"/> Living on Savings/Annuity <input type="checkbox"/> Live with parent/family/friends <input type="checkbox"/> Homeless Shelter		
	<input type="checkbox"/> Deceased <input type="checkbox"/> Other:		

**SPOUSE**

Responsible Party:			
SSN:	DOB:		
Home Address:		Phone #:	
Work Address:		Phone #:	
Gross Income:	Circle One - <input type="checkbox"/> Hourly <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly		
Hours Per Week:			

## SECTION C

### HOMELESS AFFIDAVIT

I hereby certify that I am homeless, have no permanent address, no job, savings, or assets, and no income other than potential donations from others. \_\_\_\_\_

Patient/Guarantor Initials \_\_\_\_\_

### ATTESTATION OF TRUTH

I hereby acknowledge that all the information provided herein is true and correct. I understand that providing false information will result in the denial of this Application. Additionally, depending upon applicable law, providing false information to defraud a hospital for obtaining goods or services may be considered an unlawful act. I also consent to the hospital's obtaining such credit reports and/or taking such other measures as may be necessary to verify information provided herein. I fully understand that the PHV Charity Care program(s) is a "Payor of Last Resort" program and hereby confirm all prior assignments of benefits and rights, which may include liability actions, personal injury claims, settlements, and any and all insurance benefits which may become payable, for illness or injury, provided to PHV which have provided care.

PATIENT/GUARANTOR SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

## SECTION D

### FINANCIAL ASSISTANCE SCREENING

Total Number of Dependent Family Members in Household \_\_\_\_\_

*(Include patient, patient's spouse or domestic partner, and any children the patient has under the age of 21 living in the home. If the patient is a minor, include mother/father and/or legal guardian, and all other children under the age of 21 living in the home.)*

Estimated Gross Annual Household Income \$ \_\_\_\_\_

Calculate Income to FPG Ratio: \$ \_\_\_\_\_

Gross Annual Income ÷ FPG Based on Family Size: \_\_\_\_\_%

Type of Service Check One ER  OP  IP  MULTI

Total Co-pay Amount Due: \$ \_\_\_\_\_

## SECTION E

### OFFICE USE ONLY

Family Size:	1	Acct Number(s) / Branch	Pt Type / Date of Service	Balance	W/O Amount	Co-Pay
Gross Annual Family Income:	\$				\$	\$
FPG based on Family Size:	\$					\$
Current Hospital Charges (w/ in 6 months):	\$			\$	\$	\$
Income/FPG:	%			\$	\$	\$
Income X 2:	\$			\$	\$	\$
Total Hospital Charges:	\$					

Prepared by _____	Date_____	Unit_____
Examined by _____	Date_____	Unit_____
Approved or Denied by _____	Date_____	Title_____
Denial Reason:		