

**St. Joseph Health System
Financial Assistance Application**

INSTRUCTION

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 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; and
- b. A letter explaining why you do not file a federal income tax return.

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 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:

**ST MARY MEDICAL CENTER
Patient Financial Services
PO BOX 7025
18300 HIGHWAY 18
APPLE VALLEY, CA 92307**

**St. Joseph Health System
St Mary Medical Center
Financial Assistance Application**

PATIENT/ GUARANTOR NAME		SPOUSE NAME	
ADDRESS		PHONE	
		Home	
		Work	
SOCIAL SECURITY NUMBER			
Patient/ Guarantor		Spouse	
FAMILY STATUS: List all dependents that you support (additional space available on page 4)			
Name	Age	Relationship	
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			
3. Interest & Dividends			

4. Real Estate Rentals & 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)		
UNUSUAL EXPENSES		
Please provide information on any unusual expenses such as medical bills, bankruptcy, court judgments or settlement payments (additional space available on page 4 - attach list as needed).		
Description		Amount

By signing below, I/we declare that all information provided is true and correct to the best of my/our knowledge. I/we authorize **ST MARY 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

St. Joseph Health System Mission Statement: “To extend the Catholic health care ministry of the sisters of St. Joseph of Orange, by continually improving the health and quality of life of people in the communities we serve”.

Dignity • Service • Excellence • Justice

BRIEFLY EXPLAIN YOUR FINANCIAL SITUATION-