

## INSTRUCTIONS

1. Please complete *all* areas on the attached application. 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 the application. The following documents are accepted as proof of income:

**If you filed a federal income tax return:**

- a. Federal income tax return (Form 1040) from the most recent year, including all schedules and attachments as submitted to the Internal Revenue Service;
- b. Federal W-2 Form showing wages and earnings;

**If you did not file a federal income tax return:**

- a. Two (2) most recent paycheck stubs;
- b. Two (2) most recent check stubs from any Social Security, child support, unemployment, disability, alimony or other payments;
- c. Two (2) consecutive bank statements;
- d. If you are paid only in cash, please provide a written statement explaining your income sources.

**If you have no income, please provide a letter explaining how you support yourself/family.**

4. Your application will not be processed until *all* required information is provided.
5. It is important that you complete, sign and submit the financial assistance application along with all required documentation 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:  
**Saint Joseph Hospital - Orange**  
**Patient Financial Services Department**  
**505 S. Main St., Suite 600**  
**Orange, California 92868**

## St. Joseph Health System Financial Assistance Application

Account Number	
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 (additional space available on page 4)

Name	Date of Birth	Relationship to Patient

### Employment Status

	Patient/Guarantor	Spouse
Employer Name		
Position		
Contact Person		
Contact Phone	(    )	(    )

## St. Joseph Health System Financial Assistance Application

<b>Annual Income</b>			
	Patient / Guarantor	Spouse	Total
1. Gross Wages & Salary			
2. Self-Employment Income			
3. Interest / Dividends			
4. Rentals / Leases			
5. Social Security			
6. Alimony			
7. Child Support			
8. Unemployment/Disability			
9. Public Assistance			
10. All Other Sources (attach list)			
<b>Annual Income (total lines 1-10)</b>			
<b>Qualified Monetary Assets</b>			
	Patient / Guarantor	Spouse	Total
1. Checking Account(s) Balance			
2. Savings Account(s) Balance			
3. Stocks, Bonds, CDs Value			
4. Other _____			
5. Other _____			
<b>Qualified Monetary Assets (total line 1-5)</b>			
<b>Unusual Expenses</b>			
Please provide information on any unusual expenses such as medical bills, court judgments or settlement payments (additional space available on page 4 - attach list as needed).			
Description		Amount	
<p>The undersigned declares that all information provided is true and correct to the best of his/her knowledge. The undersigned authorizes Saint Joseph Hospital to verify any information listed in this application. The undersigned expressly grants permission to contact his/her employer, banking and lending institutions, and to check his/her credit history.</p>			
_____ Signature of Patient/Guarantor	_____ Signature of Spouse		
_____ Date	_____ Date		

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

---

**St. Joseph Health System Mission Statement: “To extend the healing ministry of Jesus in the tradition 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*