

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

INSTRUCTION

Account Number: _____

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. Joseph Hospital
Patient Financial Services Department
505 S. Main Street, Suite #600
Orange, CA 92868

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ACCOUNT NUMBER: _____

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. Joseph Hospital 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

NOTES: