

# CHARITY ASSISTANCE APPLICATION

Please read the directions before completing this application. If you need assistance completing this form, please ask your provider.

## SECTION A APPLICANT INFORMATION

Home Address:	Number	Street	City	Zip Code
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Own Home    
  Rent    
  Other - Explain

Mailing Address (if different):	Number	Street	City	Zip Code
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Telephone Number(s):	Home (     )	Work (     )	Message (     )
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If no permanent address, tell us where you can be reached:

## SECTION B HOUSEHOLD/INCOME INFORMATION

1. Please list all family members (spouse, children, parents, siblings) living in your household in COLUMN I, their relationship to you in COLUMN II, and their date of birth in COLUMN III.
2. If you or any family member in your household receive earned or unearned income, (include income from employment, self-employment, tips, commissions, pensions, Social Security, child/spousal support, gifts, disability, VA or unemployment benefits, etc.), list the total amount in COLUMN V under Gross Annual Income, and the Source of each income in Column VI.

COLUMN I	II	III	IV	V	VI
Name: Last, First, Middle Initial	Relationship	Date of Birth	Social Security Number	Gross Annual Income	Source
	SELF				

*If you need more space to answer, please write on the back of this sheet of paper and check this box. "*

**I CERTIFY I HAVE READ AND UNDERSTAND THIS FORM. I DECLARE THAT THE INFORMATION I HAVE PROVIDED IS TRUE, CORRECT AND COMPLETE. I AUTHORIZE ST. FRANCIS MEDICAL CENTER TO VERIFY THIS INFORMATION, INCLUDING REQUESTING A CREDIT REPORT.**

Signature or Mark of Applicant (or legal guardian)	Date
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Signature of Witness to Mark of Applicant (or legal guardian)	Date
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**STOP!!                      THIS COMPLETES YOUR APPLICATION                      STOP!!**

**FOR PROVIDER USE ONLY**

**APPROVED FOR 350% OF THE FEDERAL POVERTY GUIDELINES**  
**YES \_\_\_\_\_ NO \_\_\_\_\_ REASON:**

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SUPERVISOR _____	DATE _____
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MANAGER _____	DATE _____
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DIRECTOR, PATIENT FINANCIAL SERVICES _____	DATE _____
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VICE PRESIDENT, FINANCE OR ADMINISTRATOR _____	DATE _____
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ST. FRANCIS  
MEDICAL CENTER  
*our mission is life*

3630 East Imperial Highway  
Lynwood, CA 90262  
(310) 900-8900

## FINANCIAL ASSISTANCE APPLICATION INSTRUCTIONS

### PLEASE READ ALL INSTRUCTIONS BEFORE FILLING OUT

- 1 Please complete all areas on the attached application. If any area does not apply to you, write N/A.
- 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.
  - a. Federal income tax return (form 1040) from the most recent year.
  - b. Federal W-2 showing wages and earnings
  - c. Most recent paycheck stubs.
  - d. If you did not file a federal income tax return, then provide the most recent paycheck stub for all wage earners in the household.
  - e. Most recent check stub from Social Security, child support, unemployment, disability, alimony or other payment source. (If you direct deposit, a copy of your bank statement showing direct deposit and amount.
  - f. If you are paid only in cash please provide a signed written statement explaining your income sources

Your application cannot be processed until all required information and/or documents are provided.

You must sign and date the application

