Antelope Valley Medical Center

Financial Assistance Application

Antelope Valley Medical Center's Financial Assistance Program provides financial assistance to patients with medically necessary healthcare needs with low-income, uninsured or underinsured, ineligible for a government program, and is otherwise unable to pay for medically necessary care based on their individual family financial situation. To determine if a patient/guarantor qualifies for financial assistance, we need to obtain certain financial information. Your cooperation will allow us to give all due consideration to your request for financial assistance.

Name _____ Address_____

Date of Birth ___ /___ /___ Social Security _____ Phone number_____

Financial Account Number(s) _____

List Dependents:

Name	Relationship	Age

Number of dependents filed on tax return: _____

Wages/Income	**Monthly**	**Annual**
Self-Wages		
Spouse/Domestic Partner Wages		
Other Family Member Wages		
Social Security/Disability Benefits		
Military Family Allotments		
Retirement/Pensions		
Unemployment Benefits		
Alimony/Child Support		
Income from Rent, Dividends, Interest		

Expenses	**Monthly**	**Annual**
Mortgage/Rent		
Utilities		
Auto Loans		
Medical Bills		
Phone/Internet		
Food/Gas		
Credit Cards		
Child Care/Other		

Please send the most recent following supporting documentation: Income Tax Filings and W-2s, 3 Bank Statements, 4 Pay Check Stubs, and proof of expenses.

My signature attests that the information I have provided on this form is accurate and true to the best of my knowledge.

_____ _____ _____

Print Applicant Name Applicant Signature Date

☐ Charity Care ☐ Discounted Care