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. Those who apply for discounted payment may receive less financial assistance than those who apply for charity care. 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 4 Pay Check Stubs.

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