To apply in person please visit:

5855 Olivas Park Drive
Ventura, CA 93003
Business Hours
Monday – Friday 9:00 am – 4:00 pm

REQUEST FOR FINANCIAL ASSISTANCE
UNCOMPENSATED CHARITY CARE / DISCOUNT PAYMENT PROGRAM
APPLICATION INSTRUCTIONS

Date: _____

Patient Name: _____

Account Number(s): _____

Total Balance for Consideration: $_____

In response to your request for financial assistance regarding the above identified account number(s), please submit the following documentation, no later than ten (10) days of the date of this letter.

The hospital may only request recent paystubs or income tax for documentation of income. The hospital may accept other forms of documentation of income but shall not require such other forms.

Patients that only apply for the discount payment program eligibility may receive less financial assistance than what may be available to them under the charity care program.

It is important that the application be complete, and all requested information is provided in order to properly assess your ability to pay all or part of the hospital bill.

(1) Formal Medi-Cal denial or acceptance

(2) Fully completed charity care/discount payment program application (enclosed with this letter)

(3) Copies of your current period payroll check stubs for the last three months. Note that this also includes public assistance (for example, Social Security, Unemployment, or Disability). If you receive your income in cash, please provide us with a written statement from your employer stating your income.

    If you currently are not receiving any income please write a brief paragraph on a separate sheet of paper stating your current financial situation. Be sure to include the date and signature. If you are receiving financial assistance or living with someone, please have him or her write a statement explaining the situation.

(4) Rent or mortgage verification.

(5) Copy of your prior 3 month's bank statements (savings, checking, IRAs, money market accounts, etc.)

(6) Copy of your prior year's tax return (the completed and signed 1040)

Please send copies of these documents because they will not be returned to you.
If you have any questions, please telephone me directly at (805) 652-5676 for assistance.

Becky S.
Patient Financial Services Supervisor
Community Memorial Healthcare

Community Memorial Healthcare
147 North Brent Street
Ventura, CA 93003

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Ventura, CA 93003

REQUEST FOR FINANCIAL ASSISTANCE

UNCOMPENSATED CHARITY CARE / DISCOUNT PAYMENT PROGRAM APPLICATION

Patient Name: _____

Patient Account Number(s): _____

Guarantor Name_____

Date of Birth: _____SS#_____-_____-_____

Phone: ( ) _____

Address: _____

City, State, Zip: _____

Spouse Name: _____SS#_____-_____-_____

Are you a U.S. Citizen? ____Yes ___No

If not, a resident alien? ____Yes ___No

If not, non-resident alien? ____Yes ___No

FAMILY STATUS: List all dependents who you support

Name	Age	Relationship
1) _____	_____	_____
2) _____	_____	_____
3) _____	_____	_____
4) _____	_____	_____

EMPLOYMENT AND OCCUPATION:

Employer: _____Position:_____

If self-employed, Name of business:
_____

Employer Address: _____

Phone Number: _____ How long employed: _____

Spouse Employer: _____ Position: _____

If self-employed, name of business:

_____

Statement of Current Income and Expenditures

Current Monthly Income:	**Patient**	**Spouse**
Gross Pay	$_____	$_____
Income from business (if self-employed)	$_____	$_____
Interest and dividends	$_____	$_____
Income from real estate or personal property	$_____	$_____
Social Security/Retirement Income	$_____	$_____
Alimony, support payments	$_____	$_____
Unemployment compensation	$_____	$_____
Other Income	$_____	$_____
Total Monthly Income	$_____	$_____

Current Monthly Expenses:	**Patient**	**Spouse**
Rent or House Payment	$_____	$_____
Real Estate Taxes	$_____	$_____
Utilities	$_____	$_____
Alimony, support payments	$_____	$_____
Education	$_____	$_____
Food	$_____	$_____
Payroll Deductions	$_____	$_____
Medical, dental and medicines	$_____	$_____
Other_____	$_____	$_____
Total Monthly Expenses	$_____	$_____
Net Monthly Income after Expenses	$_____	$_____

By signing this Application, I agree to allow Community Memorial Healthcare to contact my employer, bank and other sources, as well as request a credit history for the purpose of determining my Charity Care eligibility. I understand that I do not qualify for services under the Charity Care guidelines that I will be personally liable for the charges of the services rendered. I attest that the information provided on this application is true and accurate. If it is determined that any information provided here is false or misleading, I understand that eligibility for Charity Care will be denied.

I also understand that this application is for Community Memorial Healthcare charges only. All physician, radiology professional, Ojai emergency room professional, ambulance, anesthesiology services or pathology services are billed separately from Community Memorial Healthcare are not covered by this application.

_____ _____

(Signature of Patient or Guarantor) (Date)

_____ _____

(Signature of Co-Applicant) (Date)