Emanate Health Business Services
1325 N. Grand Ave. Suite 300
Covina, CA 91724-1016

Patient/Guarantor Name: ______________________________

Account Number (s): ______________________________

Emanate Health is committed to making health care available to everyone in our community, regardless of their ability to pay. Our financial assistance program helps low-income, uninsured or under-insured patients who need help paying for all or part of their medically necessary care.

Required Documentation

Eligibility alone is not an entitlement to coverage under Emanate Health's Financial Assistance Program. To determine eligibility and maximize the qualifying assistance/discount amount, the following documents are required when applicable:

1) Completed & signed financial assistance application
2) Current pay stubs or if self-employed, current year to date profit & loss statement to determine current income.
3) Recent tax returns and W-2 form
4) Evidence on any General Relief program benefit, Alimony, Unemployment, Disability, SSI, award letters for social security.
5) Last calendar year's filed tax return with all required schedules to determine generating assets including monetary assets.
6) Copies of prior year's 1099 for interest income, dividends, capital gains, etc.

****Copies only, no originals please****

Failure to submit the requested documentation within 30 days may result in a denial of financial assistance. Anyone found falsifying information will automatically be disqualified for financial assistance.

For more information, or help completing the application, please call us at 626-732-3100, or visit us at 1325 N. Grand Ave., Suite 300, Covina, Ca.

Sincerely,

Business Services
(626)732-3100
(8:00a.m.-4:00p.m.)

Financial Assistance Application

SECTION 1: Patient Demographics

Patient's Name: ______________________ SS # ______________ DOB: ____________

Current Address: ______________________ City: ______________ State: ____________

If the patient is a minor or if someone else claims you as a dependent; please provide the responsible parties information below.

Guarantor's Name: ______________________ SS # ______________ DOB: ____________

Current Address: ______________________ City: ______________ State: ____________

Have you previously applied for Medi-Cal or other government assistance? ☐ Yes ☐ No

Please explain: ____

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Were these services related to an accident or third party injury? ☐ Yes ☐ No

If yes, describe how your injury/accident occurred and who is responsible for covering the losses resulting from your incident?

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SECTION 2: Family Size

List all persons living in your household, their date of birth, social security # and relationship.

Name	Date of Birth	Social Security #	Relationship

Financial Assistance Application

SECTION 3: Property, Savings and Assets

Value of Home – if owned	$
Debt on Home – if owned	$
Checking Account Balance	$
Saving Account Balance	$
Assets of Business or Partnership	$
Other Assets	$

Total Assets	$

SECTION 4: Monthly Income

Please describe your income status, including your date of hire/last date of employment/retirement. If you do not have income, please describe how you meet your needs for food and shelter. If another person is providing support, please describe the type of support you are receiving, the estimated date you began receiving that support and the expected end date. Please ask the person to provide Emanate Health a letter describing the type of support, frequency and duration of the support.

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Source of Income & Required Documents

On the following page (page 4), please identify ALL source of monthly income in your household. If someone else claims you as a dependent or is supporting you financially, their financial information is required. Place a ✓ next to the source of income that applies to you and/or the persons in your household. Write the name of the person receiving the income and the total amount received per month. In addition to completing this application, please SUBMIT all supporting income documentation for the persons you have listed along with YOUR supporting income documentation, most recent filed tax return (1040), 2 months of savings/checking bank statements, and brokerage/investments statements (401/IRA).

Financial Assistance Application

Source of Income	✓	Documents Needed	Person Receiving Income	$ per Month
Wages		2 Current Paystubs		$
Hourly Rate				$
Average Monthly Hours Worked				$
Self-Employment Gross Receipts		YTD Profit & Loss Schedule 1		$
Partnership Income		YTD Profit & Loss Schedule 1		$
Social Security		Award Letter		$
Supplemental Security Income (SSI)		Award Letter		$
Unemployment		Award Letter		$
Disability		Award Letter		$
Workers Compensation		Award Letter		$
General Relief		Award Letter		$
Temporary Assistance for Needy Family (TANF)		Award Letter		$
Food Stamps/ Electronic Benefit Transfer (EBT)		Award Letter		$
Alimony		Award Letter		$
Child Support		Award Letter		$
Student Loans		Award Letter		$
Pension/ Annuities		Last Year's 1099		$
Interest Income		Last Year's 1099		$
Dividends		Last Year's 1099		$
Capital Gains				$
Gross Rental Income				$
Other				$

Total Monthly Income	$

Financial Assistance Application

Acknowledgement of Information

Pursuant to the Federal law, I am applying for Financial Assistance under Emanate Health Financial Assistance policy. I understand the information requested in this application is required for eligibility under the policy to determine if assistance will be granted. I understand by signing this application, I am consenting to allow Emanate Health designated staff representative to verify the accuracy of my information submitted. The verification approval process may include but is not limited to accessing my credit report. I declare under penalty of perjury that the information provided is true and correct. I understand the Hospital may need information in addition to the information I am submitting today. I understand failure to submit the requested documentation within 30 days of the request may result in a denial of financial assistance. I understand that I may qualify for uncompensated care or a partial discount based upon my income. If I qualify for a partial discount, I agree to pay the Emanate Health any portion deemed due by me within 30 days. Failure to pay the discount balance may result in assignment to an outside agency.

Signature : ______________________________ Date: ____________________

Should you have any questions regarding this application or if you need assistance filling out this application, please contact:

Patient Financial Services Department at (626)732-3100
Monday- Friday 8:00am-4:00pm

Please submit completed application and ALL required supporting documents to:

Emanate Health - Business Services
1325 N. Grand Ave. Suite 300
Covina, CA 91724