

APPLICATION FOR FINANCIAL ASSISTANCE

PATIENT NAME _____ SPOUSE _____
 ADDRESS _____ PHONE _____

Contact Person & Telephone: _____
 If Self-Employed, Name of Business: _____

Spouse Employer: _____ Position: _____
 Contact Person & Telephone: _____
 If Self-Employed, Name of Business: _____

CURRENT MONTHLY INCOME

Patient Other Family

	Gross Pay (before deductions)	_____	_____
<i>Add:</i>	Income from Operating Business (if Self-Employed)	_____	_____
<i>Add:</i>	Other Income:		
	Interest and Dividends	_____	_____
	From Real Estate or Personal Property	_____	_____
	Social Security	_____	_____
	Other (specify):	_____	_____
	Alimony or Support Payments Received	_____	_____
<i>Subtract:</i>	Alimony, Support Payments Paid	_____	_____
<i>Equals:</i>	Current Monthly Income	_____	_____
	Total Current Monthly Income (add Patient + Spouse)	_____	_____
	Income from above	_____	_____

FAMILY SIZE

Total Family Members _____
 (Add patient, parents (for minor patients), spouse and children from above)

	Yes	No
Do you have health insurance?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have other Insurance that may apply (such as an auto policy)?	<input type="checkbox"/>	<input type="checkbox"/>
Were your injuries caused by a third party (such as during a car accident or slip and fall)?	<input type="checkbox"/>	<input type="checkbox"/>

When applying only for discount payment program eligibility, Bakersfield Behavioral Healthcare Hospital may only request recent paystubs or income tax returns for documentation of income. Other forms of documentation of income may be requested, but may not require them. Patients applying only for discount payment program eligibility may receive less financial assistance than what may be available under our charity care program.

By signing this form, I agree to allow Bakersfield Behavioral Healthcare Hospital to check employment for the purpose of determining my eligibility for a financial discount, I understand that I may be required to provide proof of the information I am providing in the form of recent pay stubs or tax returns. Bakersfield Behavioral Healthcare Hospital will consider other forms of proof of income if submitted.

 (Signature of Patient or Guarantor)

 (Date)

 (Signature of Spouse)

 (Date)