Financial Assistance Application

Discount Payment and Charity Care for Financially Qualified Patients

Application Instructions
The attached application must be completed at the time of admission or as soon as practical after admission.

The following checklist may be used to ensure you have a supplied the required information necessary for your application to be considered for financial assistance:
Checklist of Documents Requested
☐ Completed Medicare, Medi-Cal, or Covered California application
☐ Prior year Income Tax Return as submitted to IRS OR
☐ Current period paycheck stubs; Unemployment or Disability payment stubs (2 Months' Worth)
☐ If you have no income, or proof of income documents, please provide a letter explaining how you support yourself/family.
☐ Verification of Employment

Applications received without proof of income (tax return or check stubs) cannot be processed.

For questions, please call (760) 924-4062. Completed applications and required documentation should be returned to the Mammoth Hospital Financial Counselors via email: Billing@MammothHospital.com OR via:

Mail
Mammoth Hospital
Attn: Financial Counselor
PO Box 100 PMB 700, Mammoth Lakes, CA 93546

Fax
Mammoth Hospital
Attn: Financial Counselor
(760) 934-1832 FAX

Account Number(s): _____ _____ _____ _____ Date: _____

To be considered under the Financial Assistance Program, please complete this entire form. List total number of dependents, including yourself residing at your address.
ALL INFORMATION MUST BE COMPLETE. INCOMPLETE APPLICATIONS CANNOT BE PROCESSED.

NAME: _____
First Middle Last

ADDRESS: _____
Street/P.O. Box City State Zip Code

Phone Number(s): _____ Cell Phone Number(s): _____

Social Security #: _____ Date of Birth: _____

Employer: _____ Phone Number: _____

Occupation: _____ Hourly Rate of Pay $: _____

DEPENDENTS (list each by name and age)
Please use back side of page if more room is needed.
Name Age
_____
_____
_____

SOURCE OF INCOME Annual Amount
(If married, both incomes required)
_____ $_____
_____ $_____
_____ $_____

MONTHLY EXPENSE INFORMATION
Rent/Mortgage $_____ Loans $_____ Utilities $_____ Alimony $_____
Food $_____ Child Support $_____Medical $_____ Insurance Premiums $_____

I certify that to the best of my knowledge; the above information is true and accurate. I authorize Mammoth Hospital to verify any information given on this application.

_____ _____
Patient or Responsible Party Signature Date