Hoag Orthopedic Institute

Financial Assistance Application

Applicant (Guarantor) Information			
Applicant Name:		Date of Birth:	
Address	City	State	Zip
Cell Number	Home Number:		
Marital Status: Married Single Divorced Widowed			

Co-Applicant Information			
Spouse/Domestic Partner Name:		Date of Birth:	
Address	City	State	Zip

Family (Household) Information		
First, Middle, Last Name	Date of Birth	Relationship to Applicant
1		
2		
3		
4		

Income			
Applicant		Co-Applicant	
Gross Income	$	Gross Income	$
Social Security /SSI/SSDI	$	Social Security/ SSI/SSDI	$
Public Assistance	$	Public Assistance	$
Rental Property Income	$	Rental Property Income	$
Retirement/Pension	$	Retirement/Pension	$
Work Comp	$	Work Comp	$
Unemployment	$	Unemployment	$
Child Support	$	Child Support	$
Other	$	Other	$
Total	$	Total	$

Expenses			
Auto Insurance	$	Life Insurance	$
Auto Payment	$	Medical Expenses	$
Childcare	$	Other	$
Food	$	Property Tax	$
Health Insurance	$	Phone/Cell Phone	$
House Payment	$	Utilities	$
Total	$	Total	$

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ASSIGNMENT OF RIGHTS

By signing below, I declare under penalty of perjury that the information and statements contained in this Application for Financial Assistance and all the documentation which I submit are accurate true and correct. You are hereby authorized to check my credit history in order to evaluate this application for Financial Assistance consideration.

I understand that Hoag Orthopedic Institute may make reasonable requested for additional information and verification is necessary.

I understand that the information and statements I have provided will be kept confidential by Hoag Orthopedic Institute.

I understand that the completion of the application will allow Hoag Orthopedic Institute to consider my circumstances.

I understand Hoag Orthopedic Institute makes no representation that financial assistance is guaranteed.

I/We hereby certify the above information and voluntarily authorize you to obtain credit information relative to me/us.

Applicant Signature	Date	Co- Applicant Signature	Date

It is important that you complete and submit the completed Financial Assistance Application along with all the required documents.

- Two (2) recent pay stubs or the most recent 1040 tax returns for each wage earner, including all applicable schedules and attachments.
- Copy of your most recent cancelled rent check, lease agreement or mortgage payment or a written statement from a family member or friend who is providing your room and board and/or income.
- If uninsured and applying for Charity Care, eligibility for government-funded programs must be explored. Programs include, but are not limited to: Medicare, Medi-Cal (CA), Covered California, and other state and county funded health coverage programs.

Please send your Financial Assistance Application to:

- Secure Fax: 949-764-7031
- Email: PFS@hoag.org
- Mail: Patient Financial Services 2975 Red Hill Ave, Suite 200 Costa Mesa, CA 92626

After receipt of your completed application, we will notify you of our decision in writing within 30 days of receipt. If you have any questions or wish to discuss your account, please contact us at 949-764-8400. Our business hours are Monday through Friday, 8:00 am to 4:30 pm.