Antelope Valley Medical Center

Financial Assistance Application

Antelope Valley Medical Center's Financial Assistance Program provides financial assistance to patients with medically necessary healthcare needs with low-income, uninsured or underinsured, ineligible for a government program, and is otherwise unable to pay for medically necessary care based on their individual family financial situation. To determine if a patient/guarantor qualifies for financial assistance, we need to obtain certain financial information. Your cooperation will allow us to give all due consideration to your request for financial assistance.

Name _____ Account Number_____

Address_____ Phone number_____

_____ Social Security _____

Date of Birth ___ /___ /___ Sex____ M=Male F=Female Do you own a home? Yes ( ) No ( )

Number of dependents filed on tax return: _____ Do you own other property? Yes ( ) No ( )

List Dependents: Do you own automobiles? Yes ( ) No ( )

Name	Relationship	Age	Gender

Household Banking Information **Name**_____ **Balance**_____

Business Banking Information **Name**_____ **Balance**_____

Wages/Income	**Monthly**	**Annual**
Self-Wages		
Spouse Wages		
Other Family Member Wages		
Social Security		
Unemployment Benefits		
Retirement / Pensions		
Alimony / Child Support		
Military Family Allotments		
Disability Benefits		
Income from Rent, Dividends, Interest		
Expenses	**Monthly**	**Annual**
Mortgage / Rent		
Utilities		
Auto Loans		
Hospital Bills		
Telephone		
Food		
Credit Cards		
Gasoline		
Child Care		
Other		

Please send the most recent following supporting documentation: Income Tax Filings and W-2s, 3 Bank Statements, 4 Pay Check Stubs, and proof of expenses.

My signature attests that the information I have provided on this form is accurate and true to the best of my knowledge.

_____ _____ _____

Print Name **Signature** **Date**