FINANCIAL ASSISTANCE APPLICATION INSTRUCTIONS

PLEASE NOTE: This Form Is Not An Application For The California Medi-Cal Program

CHOC requires the attached application, and the supporting documents listed below to properly evaluate your request for a possible reduction of hospital / physician expenses incurred at CHOC in Orange, CHOC at Mission Hospital, CHOC clinics, or CHOC Primary Care locations.

Please complete all sections of the application. The documents listed as required must be included with your application. Any application that is missing information or that is submitted without the required supporting documents will be returned to you.

ATTENTION: THE FOLLOWING DOCUMENTS ARE REQUIRED.

These documents must be submitted along with your Financial Assistance Application.

The two (2) most recent paycheck stubs

Federal Income Tax returns from the previous year

Please provide documentation that supports the following sources of other income including:

- Business Income (is Self Employed)
- Rental Income
- Child Support
- Alimony
- Social Security
- Unemployment Benefits
- Worker's Compensation
- Welfare / AFDC

If you have no income, or proof of income documents, please provide a letter explaining how you support yourself/family.

Please email FinancialAssistance@choc.org for a secure email link for submission of your application and supporting documents.

Completed application can also be mailed to:

CHOC
CHOC Family Payment Center
1201 W. La Veta Ave
Orange, California 92868-3874

The current published federal poverty guidelines are used in determining eligibility. CHOC Children's Financial Assistance policy is available upon request. If you need to contact the hospital regarding your application, please call contact the CHOC Family Financial Resource Center at 714-509-8600.

Thank you for choosing CHOC for your family's healthcare needs.

Patient Information

Patient Name:		
Sex: Male ☐ Female ☐		Account Number:
Patient's Date of Birth:		Date(s) of Service:
Guarantor Name:		
Address:		
Does the patient have medical insurance?	Yes No	
Has patient applied for Medi-Cal or CCS?	Yes No	
Number of Family Members / Dependents per Income Tax Submitted: (Include all children 21 and under)		Family Members Ages:

Income Information

Parent / Guarantor Information	Employer Information	Monthly Income (PRIOR to Taxes)
Parent #1 Name	Employer Name:	
		$
Parent #2 Name:	Employer Name:	
		$
Other Income:	Income Source:	
		$
		$

Annualized Income: $

I certify the information provided is true and accurate to the best of my knowledge. I have or will apply for any assistance (Medi-Cal, Healthy Families, insurance, etc.) which may be available for payment of medical services and that I will take any action reasonably necessary to obtain such assistance and will assign or pay to the hospital the amount recovered for medical services.

I understand that this application is a tool for the hospital to evaluate eligibility for financial assistance. I also understand that the hospital will verify the information which may include obtaining a credit report. If the information I have given proves to be untrue, or if I fail to comply with the referral process for Medi-Cal, Medicare, California Children's Services, or other identified programs this may result in forfeiture of the right to be considered for the Financial Assistance Program.

Signature:	Date:
Name:	Contact #:
Email:	