



## FINANCIAL ASSISTANCE PROGRAM

P: 1-415-925-7070

### STATEMENT OF FINANCIAL CONDITION

PATIENT NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

ACCOUNT NUMBER(S) \_\_\_\_\_

SPOUSE \_\_\_\_\_

PHONE \_\_\_\_\_ SSN \_\_\_\_\_

### FAMILY STATUS (List all dependents that you support)

<i>NAME</i>	<i>AGE</i>	<i>RELATIONSHIP</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

### EMPLOYMENT AND OCCUPATION

EMPLOYER \_\_\_\_\_

POSITION \_\_\_\_\_

CONTACT PERSON & TELEPHONE \_\_\_\_\_

IF SELF EMPLOYED, NAME OF BUSINESS \_\_\_\_\_

SPOUSE'S EMPLOYER \_\_\_\_\_

SPOUSE'S POSITION \_\_\_\_\_

SPOUSE'S CONTACT PERSON & TELEPHONE \_\_\_\_\_

IF SELF EMPLOYED, SPOUSE'S NAME OF BUSINESS \_\_\_\_\_

**CURRENT MONTHLY INCOME (Add gross pay before tax/deductions)**

	<i>PATIENT</i>	<i>SPOUSE</i>
ADD OTHER INCOME	_____	_____
INTEREST % DIVIDENDS FROM REAL ESTATE/PROPERTY	_____	_____
SOCIAL SECURITY	_____	_____
OTHER (PLEASE SPECIFY)	_____	_____
ALIMONY, SUPPORT PAYMENTS RECEIVED	_____	_____
SUBTRACT	_____	_____
ALIMONY, SUPPORT PAID OUT	_____	_____
EQUALS	<b>A</b> _____	<b>B</b> _____
TOTAL INCOME	_____ (A+B)	

**FAMILY SIZE**

ADD PATIENT, SPOUSE, & DEPENDENTS FROM ABOVE \_\_\_\_\_

**PATIENT:**  
**ARE YOU INSURED?**                      YES   NO      IF YES,  
PLEASE INDICATE \_\_\_\_\_

**DO YOU HAVE OTHER  
INSURANCE THAT MAY  
APPLY? (IE. AUTO POLICY)**      YES   NO      IF YES,  
PLEASE INDICATE \_\_\_\_\_

**WERE YOUR INJURIES  
CAUSED BY A THIRD PARTY?**  
(IE. CAR ACCIDENT,  
SLIP & FALL)                      YES   NO      IF YES,  
PLEASE INDICATE \_\_\_\_\_

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\_\_\_\_\_  
**PATIENT SIGNATURE**

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\_\_\_\_\_  
**SPOUSE SIGNATURE**

**DATE** \_\_\_\_\_

## **Attention:**

If you need help in your language, please call MarinHealth Medical Center at 1-415-925-7000 to obtain more information or visit the Medical Center at 250 Bon Air Road Greenbrae, CA 94904 where patients may obtain additional information. If you require aids and services for people with disabilities, like documents in braille, large print, audio, and other accessible electronic formats, please contact the Medical Center at 1-415-925-7000 or visit in person at 250 Bon Air Road, Greenbrae, CA 94904 and the Medical Center will do its best to accommodate you at no charge to you.

## **Help Paying Your Bill**

There are free consumer advocacy organizations that will help you understand the billing and payment process. You may call the Health Consumer Alliance at 888-804-3536 or go to [healthconsumer.org](http://healthconsumer.org) for more information.

## **Hospital Bill Complaint Program**

The Hospital Bill Complaint Program is a state program, which reviews hospital decisions about whether you qualify for help paying your hospital bill. If you believe you were wrongly denied financial assistance, you may

file a complaint with the Hospital Bill Complaint Program. Go to [HospitalBillComplaintProgram.hcai.ca.gov](http://HospitalBillComplaintProgram.hcai.ca.gov) for more information and to file a complaint.