Emanate Health
1325 N. Grand Ave. Ste 300
Covina, CA 91724-1016

PATIENT NAME:
ACCOUNT # :
ADMIT/SVC DATE:
TOTAL CHARGE :

Dear Valued Patient:

Emanate Health is committed to making health care available to everyone in our community, regardless of their ability to pay. Our financial assistance program helps low-income, uninsured or under-insured patients who need help paying for all or part of their medically necessary care.

Required Documentation

Eligibility alone is not an entitlement to coverage under Emanate Health's Financial Assistance Program. To determine eligibility and maximize the qualifying assistance/discount amount, the following documents are required when applicable:

1) Completed & signed financial assistance application
2) Current pay stubs or if self-employed, current year to date profit & loss statement to determine current income.
3) Recent tax returns and W-2 form
4) Evidence of any General Relief program benefit, Alimony, Unemployment, Disability, SSI, award letters for social security.
5) For full charity, last calendar year's filed tax return with all required schedules to determine generating assets including monetary assets;
6) For full charity, copies of prior year's 1099 for interest income, dividends, capital gains, etc.

****Copies only, no originals please***

Failure to submit the requested documentation within 30 days may result in a denial of financial assistance. Anyone found falsifying information will automatically be disqualified for financial assistance.

For more information, or help completing the application, please call us at 626-732-3100, or visit us at 1325 N. Grand Ave., Suite 300, Covina, Ca.

Please return the forms to our office in the enclosed self-addressed postage paid envelope.

Sincerely,

Business Services
(626) 732-3100
8:00am - 4:00pm

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FORM I

HOSPITAL FINANCIAL SCREENING ASSESSMENT FORM

This information will be used to determine eligibility for selected hospital programs and services.

Total number of dependents: _____
Total Annual Income: $_____
Total value of all assets: $ _____

Home/Property_____
Automobiles_____
Investments_____
Retirement_____
Other _____

Total Debts (including mortgages): $_____

Other special circumstances: _____
(I.e. legal judgments/bankruptcy)

Please check if either of the following conditions apply:

Disabled_____ Injury related to a crime ____

Place your signature and date below indicating you are authorizing Emanate Health Representatives to obtain a credit report.

_____ _____
Patient signature Date

_____ _____
Patient Representative/Financial Counselor Date

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Form II

Income Certification

Patient Name:

Account #:

I,_____certify that my family income for the past 12 months has been

$_____and I claim_____Dependents.

I am providing the attached W-2 and tax forms and my latest two paycheck stubs. I give permission for the hospital to verify my income information by running my credit report.

Affidavit of Financial Circumstances:

_____

_____

_____

_____

_____

_____ _____

Signature Date