ANTELOPE VALLEY
HOSPITAL
A facility of Antelope Valley Healthcare District

1600 West Avenue J • Lancaster, CA 93534 • (661) 949-5000
www.avhospital.org

FINANCIAL ASSISTANCE APPLICATION

INSTRUCTIONS

1. Please complete ***all*** areas on the attached application form. If any area does not apply to you, write N/A in the space provided.

2. Attach an additional page if you need more space to answer any question.

3. You ***must*** provide proof of income documents when you submit this application. The following documents are accepted as proof of income:

   If you filed a federal income tax return you must submit a copy of:
   a. Federal income tax return (Form 1040) from the most recent year. You must include all schedules and attachments as submitted to the Internal Revenue Service;

   If you did not file a federal income tax return, please provide the following:
   a. Two (2) most recent paycheck stubs

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

4. Your application cannot be processed until *all* required information is provided.

5. It is important that you complete and submit the financial assistance application along with all required attachments within fourteen (14) days.

6. You *must* sign and date the application. If the patient/guarantor and spouse provide information, both *must* sign the application.

7. If you have any questions, please call the Business Office at (661) 949-5781 or (800) 403-1857

8. Send your completed application to:
   Antelope Valley Hospital
   Patient Financial Services Department
   1600 West Avenue J
   Lancaster, CA 93534

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Hospital Account Number(s)	
Patient/Guarantor Name	
Spouse Name	
Address (Street)	
Address (City, State, Zip)	
Home Phone	( )
Work Phone	( )
Cellular Phone	( )
Patient/Guarantor SSN	
Spouse SSN	

FAMILY STATUS
List all dependents that you support

Name	Age	Relationship

EMPLOYMENT STATUS

	Patient/Guarantor	Spouse
Employer Name		
Position		
Contact Person		
Contact Phone Number		

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MONTHLY INCOME		
	Patient/Guarantor	**Spouse**
1. Gross Wages & Salary/Month		
2. Self-Employment Income/Month		
3. Interest & Dividends		
4. Real Estate Rentals & Leases		
5. Social Security		
6. Alimony		
7. Child Support		
8. Unemployment/Disability		
9. Public Assistance		
10. All Other Sources (attach list)		
Total Income (add lines 1 - 10 above)		

UNUSUAL EXPENSES	
Please provide information on any unusual expenses such as medical bills, bankruptcy, court judgments or settlement payments (attach list as needed.	
Description	**Amount**

By signing below, I/we declare that all information provided is true and correct to the best of my/our knowledge. I/we authorize Antelope Valley Hospital to verify any information listed in this application. We expressly grant permission to contact my/our employer.

_____
Signature of Patient/Guarantor

_____
Signature of Spouse

_____
Date

_____
Date