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 Salinas Valley Health Medical Center 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

Salinas Valley HEALTH

MEDICAL CENTER

450 East Romie Lane, Salinas, CA 93901
(831) 757-4333 • Toll free (888) 755-7864
www.salinasvalleyhealth.com

Salinas Valley Health Medical Center
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 family income 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; and
   b. A letter explaining why you do not file a federal income tax return.

   If you have no income, 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 of receipt of this application.

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 questions, please call your account representative at 831-755-0732.

8. Send or return your completed application to:

   Salinas Valley Health Medical Center
   Patient Financial Services Department
   3 Rossi Circle, Suite C
   Salinas, CA 93907
   831-755-0732

NS 8530-88 (Rev. 12/23)

Salinas Valley Health Medical Center
Financial Assistance Application

PATIENT/ GUARANTOR NAME		**SPOUSE NAME**	
ADDRESS		**PHONE**	
		Home	
		Work	
SOCIAL SECURITY NUMBER			
Patient/ Guarantor		Spouse	

FAMILY STATUS List all dependents that you support		
Name	Age	Relationship

EMPLOYMENT STATUS	
Patient / Guarantor Employer	Position
Contact Person	Telephone
Spouse Employer	Position
Contact Person	Telephone

FAMILY INCOME		
	Patient / Guarantor	**Spouse**
1. Gross Wages & Salary / Year (before deductions)		
2. Self-Employment Income / Year		
3. Other Income:		
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)		
GROSS FAMILY INCOME(add lines 1 - 10 above)		