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; and
   b. A letter explaining why you do not file a federal income tax return.

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

4. Your application for assistance 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 Financial Assistance Application. If the patient/responsible party and spouse provide information, both must sign the application.

7. If you have questions, please call the LLUMC-M Financial Assistance Unit at (951) 290-4530, between the hours of 9:00 a.m. and 5:00 p.m. Monday through Thursday, and 9:00 a.m. to 2:00 p.m. on Friday (excluding weekends and holidays). Weekends, holidays and after hours, please contact any Registration Representative for assistance.

8. Send your completed Financial Assistance Application and all required documents to:

   Loma Linda University Medical Center - Murrieta
   Patient Business Office
   28062 Baxter Road
   Murrieta, CA 92563
The purpose of this form is to determine patient/responsible party eligibility for financial assistance in accordance with the Loma Linda University Medical Center - Murrieta Charity Care/Discount Payment Policy.

**PATIENT / RESPONSIBLE PARTY**

**SPOUSE NAME**

**ADDRESS**

**PHONE**

Home: ______________________

Work: ______________________

**SOCIAL SECURITY NUMBER - PATIENT/ RESPONSIBLE PARTY**

**Spouse**

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

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<tr>
<th>Name</th>
<th>Age</th>
<th>Relationship</th>
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**EMPLOYMENT STATUS**

**Patient/Responsible party**

**Employer**

**Patient/Responsible party**

**Position**

**Employer**

**Contact Person**

**Employer Contact**

**Telephone**

**Spouse Employer**

**Spouse Position**

**Employer**

**Contact Person**

**Employer Contact**

**Telephone**
INCOME

1. Gross Wages & Salary/Year (before deductions)  Patient/Guarantor $ Spouse $
2. Self-Employment Income/Year  Patient/Guarantor $ Spouse $
3. Other Income:
   a. Interest & Dividends  Patient/Guarantor $ Spouse $
   b. Real Estate Rentals & Leases  Patient/Guarantor $ Spouse $
   c. Social Security  Patient/Guarantor $ Spouse $
   d. Alimony  Patient/Guarantor $ Spouse $
   e. Child Support  Patient/Guarantor $ Spouse $
   f. Unemployment/Disability  Patient/Guarantor $ Spouse $
   g. Public Assistance  Patient/Guarantor $ Spouse $
   h. All Other Sources (attach list)  Patient/Guarantor $ Spouse $

Total Income (add lines 1 - 3h above)  Patient/Guarantor $ Spouse $

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

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<th>Description</th>
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By signing below, I/we declare that all information provided is true and correct to the best of my/our knowledge. I/we authorize LLUMC-M to verify any information listed in this application. I/we expressly grant permission to contact my/our employer.

_______________________________________________________________
Signature of Patient/Responsible Party  Relationship to Patient  Date

_______________________________________________________________
Signature of Spouse  Date