AHMC Healthcare Inc. Financial Assistance Application

AHMC Healthcare Inc.'s Financial Assistance Program provides financial assistance to patients with medically necessary healthcare needs with low-income, uninsured or underinsured, ineligible for a government program, and is otherwise unable to pay for medically necessary care based on their individual family financial situation. To determine if a patient/guarantor qualifies for financial assistance, we need to obtain certain financial information. Your cooperation will allow us to give all due consideration to your request for financial assistance. **Please send the completed application and supporting documentation to the facility where services were rendered. Visit the Help with Paying my Bill page on https://ahmchealth.patientsimple.com/ for more information. You can also find the facility address on your statement.**

Facility: ☐Anaheim ☐Garfield ☐Greater El Monte ☐Monterey Park ☐Parkview ☐San Gabriel ☐Seton ☐Coastside ☐Whittier

Name: _____ **Sex:** _____ **Account #:** _____

Date of birth: _____/_____/_____ **Contact#:** (_____) _____-_____ **SSN:** _____-_____-_____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Check All That Apply: ☐Own a home ☐Own Other Property ☐Own Automobiles

Dependent Information: **# of Dependent on Tax Return:** _____

Name	Relationship	Age	Gender

Name of Personal Banking Institution: _____ **Balance:** $_____

Name of Business Banking Institution: _____ **Balance:** $_____

Monthly Wages/Income

Self Wages:	$_____	Retirement/Pensions:	$_____
Spouse Wages:	$_____	Alimony/Child Support:	$_____
Other Family Member Wages:	$_____	Military Family Allotments:	$_____
Social Security:	$_____	Rent/Dividends/Interests:	$_____
Unemployment Benefits:	$_____		

Monthly Expenses

Mortgage/Rent:	$_____	Utilities:	$_____
Auto Loans:	$_____	Hospital Bills:	$_____
Telephone:	$_____	Food:	$_____
Credit Cards:	$_____	Gasoline:	$_____
Child Care:	$_____	Other:	$_____

Please send the most recent following supporting documentation: Income Tax Filings or W-2s, 3 Bank Statements, 4 Pay Check Stubs, and proof of expenses.

My signature attests that the information I have provided on this form is accurate and true to the best of my knowledge.

_____ _____ _____

Print Name **Signature** **Date**

English Financial Assistance Application -
https://ahmchealth.patientsimple.com/shared/sites/ahmchealth/static/AHMC_Healthcare_FAA_English.pdf

Spanish Financial Assistance Application -
https://ahmchealth.patientsimple.com/shared/sites/ahmchealth/static/AHMC_Healthcare_FAA_Spanish.pdf