

**FINANCIAL ASSISTANCE  
PROVIDENCE HEALTH & SERVICES  
SOUTHERN CALIFORNIA REGION**

The Mary Potter Program is designed to provide financial assistance for those who have medical care needs, but have limited means to pay. Our policy has specific guidelines for qualification. Completion of the attached application for this program is required to assist you with your hospital bill. All information will be kept confidential.

Please attach the following items to the application:

- 1.** Paycheck stubs for 3 months (i.e. disability, unemployment, state aid, or employment)
- 2.** Most recent tax return or W-2
- 3.** Last 3 months of Checking and Savings Account Statements
- 4.** Proof of income for all household members.

If you have any questions, please do not hesitate to contact our customer service office at **1-800-750-7703**.

Return the completed application with items listed above to:

**Regional Business Office  
4180 West 190<sup>th</sup> Street  
Torrance, CA 90504**

**Attention: Financial Assistance Representative**

**PROVIDENCE HEALTH & SERVICES  
SOUTHERN CALIFORNIA REGION  
PATIENT FINANCIAL ASSISTANCE APPLICATION**

Date of Request: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Account No. \_\_\_\_\_

Address: \_\_\_\_\_ Date of Service: \_\_\_\_\_

City/State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

SS #: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**SECTION 1: RESPONSIBLE PARTY (Complete if different from above)**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

SS #: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Employer Telephone #: \_\_\_\_\_

**SECTION 2: EVALUATION REQUIRED BY STATE OF CALIFORNIA**

Ethnic Origin:  White  Black  Hispanic  Asian  Other Specify) \_\_\_\_\_

City/State of Birth: \_\_\_\_\_ Country of Origin: \_\_\_\_\_

Are you a U.S. Citizen or Legal Resident?  Yes  No

Do you have documentation of your status?  Yes  No

Mother's Maiden Name: \_\_\_\_\_

### SECTION 3: FINANCIAL EVALUATION

Family Members Living in Household: *Include all persons living in household. Include all INCOME (i.e. wages, public assistance, social security, unemployment, alimony, and child support)*

Name	Age	Relationship	Annual Income
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

*Monthly Expenses:*

Mortgage or Rent Payments: \_\_\_\_\_

Car Payments: \_\_\_\_\_

Utilities: \_\_\_\_\_

Other: (briefly describe) \_\_\_\_\_

*List all Debts (greater than \$500.00):*

Description Amount

_____	_____
_____	_____
_____	_____

*List all Assets:*

Do you own your home?  Yes  No      Market Value \_\_\_\_\_

Do you own any cars/trucks?  Yes  No

Other assets: \_\_\_\_\_

\_\_\_\_\_

#### SECTION 4: ADDITIONAL INFORMATION

*Please make additional comments about your household's financial circumstances that affect your ability to pay the hospital bill:*

#### SECTION 5: CERTIFICATION

*I, \_\_\_\_\_, (person responsible for paying hospital bill) hereby certify that the information contained in the above financial questionnaire is correct and complete to the best of my knowledge. I further understand that intentional misrepresentation or falsification of any information contained in the questionnaire is punishable by law. According to the Fair Debt and Practice Act, the hospital has the right as a creditor to check your credit status with credit agencies. Your signature below will signify that you have been notified of such:*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
*Patient or Responsible Party*

#### FOR BUSINESS OFFICE USE ONLY

Approved Assistance:  Full  Partial  Not Approved

Payment Arrangement:  Yes  No      Amount per Month: \_\_\_\_\_