LOS ROBLES
REGIONAL MEDICAL CENTER
Part of Los Robles Health System

Los Robles Regional Med Ctr
P.O. Box 290969
Nashville, TN 37229

Dear Patient/Responsible Party:

Thank you for choosing Los Robles Regional Med Ctr for your recent health care needs. Upon review of your account, we recognized that you may qualify for Financial Assistance.To be considered for our financial relief programs, please complete, sign, and return the enclosed Financial Assistance Application and provide appropriate supporting documentation. We ask that you submit this information within fourteen (14) days of receipt but will accept your application at any time.

The preferred supporting documentation is your recent Income Tax Return. A recent Income Tax Return is considered a tax return for the year you received your first patient bill or 12 months before your first patient bill. If you are unable to provide a recent Income Tax Return, as an alternative, you may provide the most current year's Income Tax Return (if not the recent Tax Return as defined above); please provide any two of the following:

* Recent Pay Stubs (or other written documentation from income sources)
* Supporting W-2
* Supporting 1099's
* Copies of all bank statements for the last 3 months
* Current Credit Report

If, for any reason, you cannot provide us with the requested information, please attach a written statement explaining why you cannot provide the information requested.

Please allow twenty-one (21) business days for our review process. We will notify you of our financial assistance determination in writing. If you have any questions or concerns, please feel free to contact Customer Service at any time.

Sincerely,
Customer Service
Phone: 800-307-7135
Fax: 833-336-8190
Hours: 8:30AM-5:00PM

PO Box 290969
NASHVILLE, TN 37229

Financial Assistance Application

Hospital Name: _____
Account Number: _____
Patient Name: _____
Patient Social Security Number: _____
Responsible Party Name: _____
Responsible Party Social Security Number: _____

“Patient's family” means the following:

(1) For persons 18 years of age and older, spouse, domestic partner, as defined in Section 297 of the Family Code, and dependent children under 21 years of age, or any age if disabled, consistent with Section 1614(a) of Part A of Title XVI of the Social Security Act, whether living at home or not.

(2) For persons under 18 years of age or for a dependent child 18 to 20 years of age, inclusive, parent, caretaker relatives, and parent's or caretaker relatives' other dependent children under 21 years of age, or any age if disabled, consistent with Section 1614(a) of Part A of Title XVI of the Social Security Act.

Name:	Age:
_____	_____
_____	_____
_____	_____
_____	_____

Employment (Patient/Responsible Party)

Employer Name:			
Hourly Rate:		Hours Worked Per Week:	
Current Gross Weekly, Monthly or Yearly Income (before taxes):			
If unemployed, date last worked:			

Spouse Employment

Employer Name:			
Hourly Rate:		Hours Worked Per Week:	
Current Gross Weekly, Monthly or Yearly Income (before taxes):			
If unemployed, date last worked:			

Type of Supporting Documentation Provided (check one of the following for the appropriate)

Preferred documentation for all patients:

Recent Income Tax Return (For the year you received your first patient bill or 12 months before your first patient bill)	☐
Most Current Year’s Income Tax Return	☐

For patients who are unable to provide the preferred supporting documentation above please provide two pieces of supporting documentation from the list below:

Recent Pay Stubs (or other written documentation from income sources)	☐
Supporting W-2	☐
Supporting 1099's	☐
Copies of all bank statements for last 3 months	☐
Current Credit Report	☐

Although not required, have you applied for Medicaid or any other State/County Assistance?

☐Yes ☐No

If yes and known, Case Number: _____Date Applied: _____

I, the undersigned, certify that the above information is true and accurate to the best of my knowledge. I understand that the information submitted is subject to verification. In the review process, a credit report may be requested to verify information provided in this application. I understand that falsification of information submitted may jeopardize my consideration for the program. Furthermore, to qualify for this program, I understand I must apply for any and all assistance that may be available to help pay this hospital bill prior to completing this application.

Signature: _____ Date: _____
(Patient, Responsible Party, etc.)