Mee Memorial Healthcare System

Discount Payment and Charity Care for Financially Qualified Patients

Thank you for choosing Mee Memorial Healthcare System as your healthcare provider. This application is provided to you to determine if you meet the Federal requirement for Charity Care at Mee Memorial Healthcare System. Eligibility is based only on family size and income. If you have any questions or need help filling out this application, please call the Financial Assistance/Charity Care Department at (831) 386-7306.

Application Instructions

The following checklist may be used to ensure you have supplied the required information necessary for your application to be considered for financial assistance

Checklist of Documents Requested

- ☐ Completed Medicare, Medi-cal, Covered California application **(optional)**
- ☐ Prior year income tax return as submitted to the IRS **or**
- ☐ Driver's License or State Identification Card
- ☐ Current period paycheck stubs, unemployment or disability payment stubs (2 months' worth)
- ☐ If you have no income or proof of income documents, please provide a letter explaining how you support yourself/family.
- ☐ Verification of employment

This application must be filled out completely. An incomplete application will be returned and will delay the application processing time. Applications received without proof of income (tax return or check stubs) cannot be processed. Completed applications and required documentation may be returned to the Mee Memorial Healthcare System's Financial Counselors by:

Mail:

Mee Memorial Healthcare System
Attn: Financial Counselor
300 Canal Street
King City, CA 93930

Fax:

Mee Memorial Healthcare System
Attn: Financial Counselor
Phone: 831-386-7306
Fax: 831-385-7188

Mee Memorial Healthcare System

Account #(s): _____ _____ _____ _____ _____

Date:_____

In order to be considered under the Financial Assistance Program, please complete this entire form. List the total number of dependents, including yourself, residing at your address.

ALL INFORMATION MUST BE COMPLETED. INCOMPLETE APPLICATIONS CANNOT BE PROCESSED.
Name:_____ First Middle Last
Address:_____ Street City State Zip code
Phone number:_____ Cell number:_____
Social Security number *(optional):*_____ Date of birth:_____
Employer:_____ Phone number:_____
Occupation:_____ Hourly rate of pay (in dollars):_____

Dependents *(list each by name and age)*: *Please use back side of page if more room is needed*	**Name**	**Age**

Source of income *(if married, both incomes required):*	Annual amount
	$
	$
	$

Monthly Expense Information *(optional):*			
Rent/Mortgage $_____	Utilities $_____	Food $_____	Medical $_____
Loans $_____	Alimony $_____	Child support $_____	Ins. Premiums $_____

I certify that to the best of my knowledge, the above information is true and accurate. I authorize Mee Memorial Healthcare System to verify any information given on this application.

Patient/Responsible Party Signature:_____ Date:_____

Mee Memorial Healthcare System
300 Canal Street • King City, CA 93930
(831) 385-6000

Financial Assistance Application

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