Marina Del Rey Hospital

A CEDARS-SINAI AFFILIATE

APPLICATION FOR FINANCIAL ASSISTANCE

Patient Name:_____

Patient Account or Medical Record Number:_____

Date of Birth:_____ Last 4 Digits of SS#: XXX-XX-_____

Best Daytime Telephone Number: ( )_____-_____

Address:_____

City:_____ State:_____ Zip:_____

Spouse's Name:_____ Last 4 Digits of SS#: XXX-XX_____

Are you a U.S. Citizen? Yes No

If not, a resident alien? Yes No

If not, a non-resident alien? Yes No

Family Status: List all dependents that you support (if more than 4 use separate page)

Name:	Age:	Relationship:

Employment and Occupation

Employer:_____ Position:_____

If self-employed, name of business:_____

Employer address:_____

Telephone: ( )_____-_____ How long employed:_____

Spouse's Employer:_____ Position:_____

If self-employed, name of business:_____

Current Monthly Income	**Patient**	**Spouse**	**Total**
Gross Pay (Salary)	$	$	$
Net Self-Employment Income	$	$	$
Interest and Dividends	$	$	$
Real Estate or Rental Property	$	$	$
Social Security/Retirement/Disability	$	$	$
Alimony, Support Payments	$	$	$
Other	$	$	$
Total Monthly Income	$	$	$

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Essential Living Expenses	**Patient**	**Spouse**	**Total**
Rent or Mortgage	$	$	$
Real Estate Taxes	$	$	$
Utilities and Telephone	$	$	$
Alimony, Support Payment	$	$	$
Auto Loan/Lease Payment	$	$	$
Education	$	$	$
School/Childcare (Minor Dependents)	$	$	$
Food	$	$	$
Insurance3 (Home/Auto)	$	$	$
Other Expenses	$	$	$
Total Monthly Expenses	$	$	$

Deudas médicas (Saldo total que debe)	**Patient**	**Spouse**	**Total**
Outstanding Medical Debt (**MDRH**)	$	$	$
Other Medical Debt	$	$	$
Total Medical Debt	$	$	$

Assets (Exclude Retirement Accounts)	**Patient**	**Spouse**	**Total**
Stock and Bonds	$	$	$
Money Market/Brokerage Accounts	$	$	$
Certificates of Deposit	$	$	$
Total Assets	$	$	$

By signing this application, I agree to allow Marina Del Rey Hospital to check my employment and request a credit history.

_____ _____

(Signature of Patient) (Date)

_____ _____

(Signature of Spouse) (Date)