Addendum A

Financial Assistance Application Instructions

Torrance Memorial Medical Center's financial assistance program was established to help those patients who are unable to pay for all or part of their health care services.

You must complete the attached Financial Assistance Application and provide the "Required Information" listed and checked under item VIII of the Financial Assistance Application to be considered for the financial assistance program.

Your application cannot be processed until all of the required information is provided. It is important that you complete and submit the Financial Assistance Application along with all the required attachments within fourteen (14) days.

You must sign and date the application. If the patient/guarantor and spouse provide information, both must sign the application. If you have questions or require assistance, please call (310) 517-4765 to speak with our Financial Counselor. Send your completed application to:

Torrance Memorial Medical Center
Patient Financial Services Department
3330 Lomita Boulevard
Torrance, CA 90505

We will notify you with the results in writing within 45 days of receipt of a completed application including the required attachments.

Torrance Memorial Medical Center
Financial Assistance Application

I. Patient Information:

Name _____ Social Security # _____

Address _____ Date of Birth _____

City_____ State _____ Zip code _____

Home Phone #_____ Cell Phone # _____ Work Phone #_____

Occupation _____ Employer/Address _____

Has the patient been declared permanently disabled Yes/No ____

II. Spouse Information: (or Parent if Patient is less than 18 Years old)

Name _____ Social Security # _____

Address _____ Date of Birth _____

City_____ State _____ Zip code _____

Home Phone #_____ Cell Phone # _____ Work Phone #_____

Occupation _____ Employer/Address _____

III. Other Parent: (if Patient is less than 18 Years old)

Name _____ Social Security # _____

Address _____ Date of Birth _____

City_____ State _____ Zip code _____

Home Phone #_____ Cell Phone # _____ Work Phone #_____

Occupation _____ Employer/Address _____

IV. List All Persons Living in Your Household, Including Applicant:

Name	**Relationship**	**Age**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

V. Monthly Income Total (List Detail Below): $_____

Patient Wages _____ Spouse Wages_____

Parent Wages (If patient is less than 18 years old.) _____

Social Security _____ Non-Deferred Pension_____

Disability _____ Unemployment _____

Public/Gov't Assistance_____ Alimony/Child Support_____

Rental Property Income _____ Other (Describe Source)_____

VI. Monthly Living Expenses Total (List Detail Below): $_____

Rent/Mortgage_____ Alimony/Child Support_____

Food/Supplies_____ Utilities_____

Clothing_____ Insurance_____

Car/Transportation/Fuel_____ School/Child Care_____

Credit Card, Other_____ Laundry/Cleaning_____

Clothing_____ Health/Life Insurance_____

VII. Assets:

Checking Account Balances_____ Savings Account Balances__ _____

Stock, Bonds, Money Market, etc. _____ If Self Employed, Business Value_____

Real Estate other than Primary Home_____ Other (describe)_____

VIII. Required Information: Please check that you have included the following -

( ) Copy of the federal income tax return Form 1040 for the most recent year;

( ) Copy of last 3 months statements for all bank and investment accounts;

( ) Two most recent paycheck stubs showing current pay period and year-to-date earnings;

( ) If you are self-employed, please include a copy of the last 12 month's financial statements and the last year's tax return.

( ) If you have no income, please provide a letter explaining how you support yourself/family.

IX. Authorization:

I hereby certify the information contained in the above application for financial assistance is correct and complete to the best of my knowledge. I authorize Torrance Memorial Medical Center to verify any or all information given and understand that a credit report may be run as part of this verification process.

_____ _____

Responsible Person's Signature Date