John Muir Magnetic Imaging
2125 Oak Grove Rd, Suite 200
Walnut Creek CA 94598
925-296-7156 Main
925-296-7174 Fax

To Whom It May Concern.

Please find attached a financial assistance application, we are partnered with John Muir Health. Please fill out in the entirety and return with your proof of income for review and approval for a financial assistance discount of up to 75%.

Sincerely,

Billing Follow-Department

Please note: Proof of income is required to be reviewed for approval of an assistance discount. The acceptable documentation is listed below: **Please provide at least two of the below for consideration of financial assistance discounts.**

- Recent check stubs
- Recent Tax return
- Unemployment stubs
- Disability letter showing income
- Social Security statement showing annual income

Once all information is attached to the application, please mail to the address above or fax to the attention of: Billing

Thank you.

1. PATIENT INFORMATION		
Last Name	**First Name**	**DOB:**

2. APPLICANT INFORMATION	Relationship to Patient ☐Self ☐Spouse ☐Parent ☐Other		Marital Status ☐Married ☐Single	
Last Name	**First Name**		**Date of Birth**	**Social Security Number**
Street Address (No PO Boxes)	**City**	**State**	**County**	**Zip**
How long at this address?	**Are you currently employed?**			**How long?**
Home Phone	**Cell Phone**			**Other Contact**

3. GENERAL INFORMATION

Does the patient have a Legal Conservator? ☐Yes ☐No (If yes, please provide the Conservator information below)

Last Name	First Name	Relationship to Patient ☐Self ☐Spouse ☐Parent ☐Other _____		
Street Address	**Apt/Ste**	**City**	**State**	**Zip**

4. FAMILY AND LIVING ARRANGEMENT INFORMATION
(For the person financially responsible for the account, if different than the patient)

Including yourself, how many people live in your household? _____

How many household members contribute to your finance _____

How many household members live in your household under the age of 21 years, which you are financially responsible for?_____

Name	Age	Income	Relationship		

Do you own your home? ☐Yes ☐No

Are you living in the residence of your parent or another adult? ☐Yes ☐No

Do you pay rent? ☐Yes ☐No Amount of rent per month? _____

Do you currently receive financial assistance for attending school? ☐Yes ☐No
Total amount of financial support: $_____/semester or $_____/ year

Do you currently receive government support? Please check all that apply.
☐Food Stamps ☐Housing Assistance ☐Payment of work injury
☐Disability ☐Welfare/WIC
☐Other (please specify): _____

Does your parent or guardian claim you as a dependent on their income tax? ☐Yes ☐No

Did you file taxes last year? ☐Yes ☐No
Was your adjusted gross income less than $ 14,600 ☐Yes ☐No

5. EMPLOYMENT AND HEALTH INSURANCE INFORMATION
(For the patient on the account)

Are you currently employed or were you employed at the time you had your medical service?
☐Yes ☐No
Does your employer offer Health Insurance to its employees? ☐Yes ☐No
Are you covered by this health insurance? ☐Yes ☐No
If no, please explain why. _____

Is your spouse/domestic partner (or parent, if patient is a minor) currently employed or was employed at the time you had your medical service? ☐Yes ☐No
Does your spouse/domestic partner's (or parent, if patient is a minor) employer offer Health Insurance to its employees? ☐Yes ☐No
Are you covered by this health insurance? ☐Yes ☐No
If no, please explain why. _____

6. OTHER PROGRAMS
(For the patient on the account)

Have you applied for any of the following programs listed below within the last 12 months of this application? Please check any programs that apply.
☐Medi-Cal ☐Healthy Families ☐Medicare ☐Basic Adult Care
☐Victims of Violent Crime ☐State Disability

7. SUPPORTING DOCUMENTATION
(REQUIRED FOR ALL ADULTS LIVING IN HOUSEHOLD THAT CONTRIBUTE TO YOUR FINANCES)

Application may be denied if all documents are not provided. If a document is unavailable, please explain why.

- Copy of Income Tax Return (1040 Form) that was last filed for every member of your household who filed taxes. OR
- Current pay stubs (last three months)
- School Financial Assistance (if applicable)
- Copy of Social Security, Disability, Pension and/or Unemployment allotment letter (if applicable).
- Copy of Child Support court order or deposit slip (if applicable)

8. COMMENTS

Enter any additional information you want to state that is not reflected on this application.

9. SIGNATURE AND DATE (REQUIRED OF APPLICANT)

I certify that all information is true and complete, and hereby authorize John Muir Health to request a credit report and/or verify any of the above information as deemed necessary. I understand that incomplete applications, including an application missing a signature, may be denied. I agree to notify John Muir Health of any changes to my financial circumstances that may affect my eligibility for financial assistance.

Applicant Signature

_____

Date

_____