marinhealth℠
Medical Center

FINANCIAL ASSISTANCE PROGRAM

P: 1-415-925-7070

Name: _____ Date: _____

Account Number(s): _____

Dear Patient,

In order to process your application for financial assistance, please include the following information with your completed application:

- Copies of your 2 most recent pay stubs
  - *If unemployed:* Copy of monthly unemployment check
  - *If disabled/retired:* Copy of monthly social security/disability check
- Most Current Federal Tax Return (if self-employed, please include all schedules)
- Copies of bank statements for the most recent 2 months
- If you claim no income, you must provide documentation for how you support yourself

In the event that a Financial Assistance Application is received, but only partially completed, we will send you a request for the documentation necessary. Please note that until **all** requested information has been supplied, we will not submit your application for review, and you will continue to be billed for the total amount due.

Please return this information **within 25 days** from the date of this letter. Please be sure to include the department that your information is to be forwarded to:

Mail: MarinHealth Medical Center
Attn: Financial Assistance Department
75 Rowland Way, Suite 300
Novato, CA 94945

Fax: 1-415-507-0713
Attn: Financial Assistance Department

We appreciate your timely response.

Sincerely,

Patient Financial Services

Helpful Hints

- If unable to provide something which has been requested, please send a letter explaining why.
- Your bank statement must show all deposits/withdrawals. If your deposits do not match your stated income, please explain why.
- If you are self-employed, please send in both personal/business bank statements.
- Please be sure to submit all information requested for both you, and your spouse.