



# Medical Financial Assistance Application - Kaiser Foundation Hospital

Applicant Name(s): \_\_\_\_\_ Medical Record #(s): \_\_\_\_\_

Number of Family Members in Household: \_\_\_\_\_ Phone #: \_\_\_\_\_

Do you own any rental property:  Yes  No Applied for Medi-cal:  Yes No

Type of Assistance Applied for:  Pharmacy Medications  Registration Co-Pays

Other Describe \_\_\_\_\_

## Applicant/Guardian

## Spouse

\_\_\_\_\_  
Last Name, First Name, Middle Initial

\_\_\_\_\_  
Last Name, First Name, Middle Initial

\_\_\_\_\_  
Social Security Number      Date of Birth

\_\_\_\_\_  
Social Security Number      Date of Birth

\_\_\_\_\_  
Current Street Address      Apt #

\_\_\_\_\_  
Current Street Address      Apt #

\_\_\_\_\_  
City      State      Zip

\_\_\_\_\_  
City      State      Zip

## Monthly Income

## Monthly Income

Salary / Wages      \$ \_\_\_\_\_

Salary / Wages      \$ \_\_\_\_\_

Alimony / Child Support      \$ \_\_\_\_\_

Alimony / Child Support      \$ \_\_\_\_\_

Pension      \$ \_\_\_\_\_

Pension      \$ \_\_\_\_\_

Social Security / SSI / SDI      \$ \_\_\_\_\_

Social Security / SSI / SDI      \$ \_\_\_\_\_

Other \_\_\_\_\_      \$ \_\_\_\_\_

Other \_\_\_\_\_      \$ \_\_\_\_\_

Monthly Gross      \$ \_\_\_\_\_

Monthly Gross      \$ \_\_\_\_\_

## Current Assets

## Current Assets

\_\_\_\_\_  
Checking Account Name      \$ Balance

\_\_\_\_\_  
Checking Account Name      \$ Balance

\_\_\_\_\_  
Savings Account Name      \$ Balance

\_\_\_\_\_  
Savings Account Name      \$ Balance

\_\_\_\_\_  
Other Assets (CD's, IRA's, Mutual Funds)      \$ Balance

\_\_\_\_\_  
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