

Yuma Regional Medical Center Financial Assistance Application

To apply for Financial Assistance:

1. Complete this application
2. Attach copies of last 30 days income unless otherwise specified.
3. Submit to Patient Financial Services at Yuma Regional Corporate Center.

Corp # _____

Account # _____

GENERAL INFORMATION

Patient's name Last First M.I. Social Security Number Date of birth

Marital status Spouse's name Last First M.I. Telephone No. Home/work

Person responsible for paying the bill Relationship to patient Telephone No. Home/work

Patient's address Street Apt No. City State Zip Date of Hospital Services

Family Members	Age/Sex	Relationship to Patient	Source of Income or Employer	Birthplace
1.				
2.				
3.				
4.				

If more than 4 in family list under extenuating situation.

HOUSEHOLD INCOME

	PERSON 1	PERSON 2	PERSON 3
NAME:	_____	_____	_____
Monthly gross income (attach verification)\$	\$ _____	\$ _____	\$ _____
Unemployment, if so, how long	\$ _____	\$ _____	\$ _____
Social Security, pensions	\$ _____	\$ _____	\$ _____
Alimony/child support	\$ _____	\$ _____	\$ _____
Government assistance, food stamps	\$ _____	\$ _____	\$ _____
Other sources of income	\$ _____	\$ _____	\$ _____
Checking account balances	\$ _____	\$ _____	\$ _____
Savings account balances	\$ _____	\$ _____	\$ _____
Stocks, bonds, IRA's, investments	\$ _____	\$ _____	\$ _____
Other assets	\$ _____	\$ _____	\$ _____

If you reported \$0.00 income above, please have the support statement on the back of this form completed by the person(s) helping to support you and/or your family.

VEHICLE

	VEHICLE1	VEHICLE2	VEHICLE3
Make/Year	_____	_____	_____
Monthly payment	_____	_____	_____
Value	_____	_____	_____

MONTHLY EXPENSES/BILLS

<input type="checkbox"/> Rent \$ _____	<input type="checkbox"/> Mortgage \$ _____	Mortgage Balance \$ _____	Value \$ _____
APS, Water, Gas \$ _____		Health Insurance \$ _____	
Child Care \$ _____		Healthcare bills \$ _____	
Alimony/Child support \$ _____		Medications \$ _____	
(Childs name) _____			

COMMENTS OF EXTENUATING SITUATION (attach another page if needed)

SUPPORT STATEMENT

For applicants who stated zero income, the person(s) providing the applicant with basic financial support must provide a brief explanation of that financial support. List services, if any, that you are receiving from the applicant for providing this support.

I hereby certify and verify that all of the foregoing information given is true and correct to the best of my knowledge and belief. I understand that my signature does not obligate me to be financially responsible for charges rendered to the person for whom I am providing basic financial support.

Signature of person providing financial support to applicant _____

Address _____
Street Apt No. City State Zip

All information given for this financial assistance application is true and accurate to the best of my ability. If any information is determined to be false, I understand that it will disqualify me from Yuma Regional Medical Center financial assistance immediately.

Parent/responsible party signature

Date completed

Hospital representative signature

Date completed/reviewed

MedAssist Use Only:

- Are you interested in applying for AHCCCS? _____
- Are you able to come to the office for an interview? _____ Do you need transportation? _____
- Do you have any other health insurance? _____
- Are you pregnant? _____ Due date _____ Single pregnancy? _____
- Does anyone in the household have a chronic illness? _____
- Is everyone in the household current on their shots? _____
- Do you own, lease or maintain a home outside of Arizona? _____

If you have questions, please contact us at (928) 336-7030 or 1-800-726-9264 (outside Yuma area only).

Yuma Regional Corporate Center **physical address:** 399 West 32nd Street • Yuma, Arizona 85364

Mailing address: 2400 South Avenue A • Yuma, Arizona 85364