FRESNO SURGICAL HOSPITAL
AN AWARD-WINNING PHYSICIAN OWNED HOSPITAL

Thank you for your interest in our Financial Assistance Program. If you and/or a family member have applied for financial assistance at Fresno Surgical Hospital within the last six (6) months, please contact our office at (559) 447-7735 before completing this application.

Please return the completed application and all applicable documents listed below within thirty (30) days:

- **Three (3) months complete, itemized bank statements for all checking, savings, and/or investment accounts showing deposits and withdrawals. Please provide explanation for all deposits. (Required)**

- **Proof of earned and/or unearned income as documented below. (Required)**

1. Three (3) recent pay stubs for yourself, spouse and all dependents showing pay rate and hours worked OR
2. Current, or most recently filed, federal tax return for yourself and spouse OR
3. Contribution statement from family/friends stating how living expenses are being met AND
4. Any of the following documents, as applicable for yourself, spouse and all dependents:
    - Most recent tax return including Profit/Loss statement if self-employed
    - Most recent tax return for verification of dependents
    - Unemployment benefits statement
    - Student financial aid award letter
    - Determination letter for public assistance (e.g., CalFresh, Medi-Cal, etc.)
    - Social Security and/or Social Security Disability award letter or check
    - Dividend, interest and income from any other source (e.g., rental income, alimony income, retirement benefits, etc.).

If you are unable to provide any of these documents, please provide a letter of explanation as to why the documents were not returned.

Please return the financial assistance application and supporting documents to:

Fresno Surgical Hospital
Business office
6121 N Thesta Suite #101
Fresno, Ca 93710

Please allow approximately 30 days for processing once we have received a completed application. If you have any questions or require information in another language, please contact our office at the number listed below.

Sincerely,

Fresno Surgical Hospital
Customer Service
(559) 447-7735

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NOTICE INFORMING INDIVIDUALS ABOUT NONDISCRIMINATION AND ACCESSIBILITY REQUIREMENTS

Fresno Surgical Hospital, honor the sacredness and dignity of every person, complies with applicable Federal Civil Rights laws, and does not discriminate on the basis of protected classes, including but not limited to, race, color, national origin, age, disability or sex.

Fresno Surgical Hospital: Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language and interpreters services through video and audio interpreter system network.
- Written information in other formats such as large print, audio, accessible electronic and other formats.

Provide free language services to people whose primary language is not English, such as:

- Qualified interpreters services
- Information written in other languages

If you need these services, please contact us at (559) 447-7735

If you believe that Fresno Surgical Hospital has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance in person, by mail, fax or email to:

Fresno Surgical Hospital, Attn:
Risk Management
6125 N Fresno Street
Fresno, Ca 93710
559-436-3406
Email: cqo@fshosp.com

You can also file a civil rights complaint with the US Department of Health & Human Services, Office of Civil Rights electronically via web, by mail or phone to:

Department of Health & Human Services 200
Independence Avenue, SW, Room a509F,
HHH Building, Washington, DC 20201
Web https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Phone 1-800-368-1019 TTY 1-800-537-7697

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Spanish

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-559-447-7735

Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-559-447-7735

Chinese

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-559-447-7735

Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-559-447-7735.

Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.)번으로 전화해 주십시오. 1-559-447-7735.

Armenian

ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-559-447-7735.

Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните . 1-559-447-7735.

Hindi

ध्यान द: य द आप हद बोलते ह तो आपके लए मुफ्त म भाषा सहायता सेवाएं उपलब्ध ह।) पर कॉल कर ।1-559-447-7735.

Japanese

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます）まで、お電話にてご連絡ください。1-559-447-7735.

French

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-559-447-7735.

Panjabi

ਧਆਨ ਦਓ: ਜੇ ਤੁਸ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤ ਭਾਸ਼ਾ ਵੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ।) ਤੇ ਕਾਲ ਕਰੋ। 1-559-447-7735.

Portugese

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para . 1-559-447-7735

German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-559-447-7735

Farsi

هجوت: امش یارب ناگیار تروصب ینابز تالیهست، دینک یم وگتفگ یسراف نابز هب رگا
دشاب یم مهارف. اب سامت دیریگب1-559-447-7735

Cambodian

ប្រយ័ត្ន៖ បើបេ ំ ិនអ កនិយ ែបើ ំ ខ រ, បេ ំ ិសជ ំ ន ួ
ែយជក ែ ិ ិ ែ ីចនសំ ប់ប ំ រអក។ ចូរ ទូរស័ព ។ 1-559-447-7735

Thai

เรียน: พดภาษาไทยคณสามารถใช้บริการชว่ ยเหลือทางภาษาได้ฟรี โทร 1-559-447-7735
ถ้าคณ

Lao

ໂປດຊາບ: ຖ້ າຫ ່ ານເວ ົ້ າພາສາ ລາວ, ອ ຕ ້ ານພາສາ, ໂດຍ ໍ ບ ເ ສ ັ ງ ສ ່ ຫ ,
ການບ ິ ລ ການ ຊ ່ ວຍ ິ ຫ

ແມ ່ ນ ິ ມ ີ ຢ ູ ່ ໃ ຫ ້ ທ ່ ານ. ໂ ທ 1-559-447-7735.

Arabic

) - ةظوحلم: إذا تنك تحتدث ذكرا ةغللا ةدعاسملا تامدخ نإف، ناجملاب كل رفاوتت ةيوغللا 1 مقرب لصتا.
.- مكبلاو مصلا فتاه: 1-559-447-7735.

Hmong

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-559-447-7735.

Samoan

MO LOU SILAFIA: Afai e te tautala Gagana fa'a Sāmoa, o loo iai auaunaga fesoasoan, e fai fua e leai se totogi, mo oe, Telefoni mai: 1-559-447-7735.

Hawaiian

E NĀNĀ MAI: Inā hoʻopuka ʻoe i ka ʻōlelo [hoʻokomo ʻōlelo], loaʻa ke kōkua manuahi iā ʻoe. E kelepona iā : 1-559-447-7735.

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CONFIDENTIAL APPLICATION FOR FINANCIAL ASSISTANCE

Professional services provided by affiliated physicians or other providers may be billed separately. Application of Financial Assistance is at the discretion of those providers in accordance with their policies, procedures, and applicable regulations. The information provided in this application may be provided to affiliated providers to assist the patient. Fresno Surgical Hospital honors the sacredness and dignity of every person, complies with applicable federal and state laws, and does not discriminate on the basis of protected classes, including but not limited to, race, color, national origin, age, disability or sex.

Patient Name			Date of Birth
Street Address		Telephone	Message Phone
City/State/Zip			Social Security Number
Mailing Address (if different) or email if preferred			

Please provide the following information for yourself (if not the patient), spouse and dependents:

Name	SSN	Date of Birth	Relationship to Patient

Please list all account numbers and/or dates of service to be considered for financial assistance:

Patient Name	Account #	Date of Service	Medical Balance

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Healthcare Marketplace Status

Have you applied for Insurance?	□ No	□ Yes	If Yes, Name/ID
If Yes, did you apply through:			□ Medicaid - State □ Health Exchange/ Healthcare.gov □ Other _____
Were you approved for an insurance plan?	□ No	□ Yes	
Have you enrolled and paid the premium for an insurance plan?	□ No	□ Yes	

Monetary Assets

Checking Account Balance	Bank:	$
Savings Account Balance	Bank:	$

Employment

Person Employed	Employer	Gross Pay Period	# of Pay Periods	Annual Gross
		$		**$**
		$		**$**
		$		**$**
		$		**$**

Other income Source	**Monthly**	**Annually**
Alimony	$	$
Public Assistance Program Type_____(e.g., Cash, Food Stamps, etc.)	$	$
Payment from Retirement Plan	$	$
Social Security / Social Security Disability	$	$
Unemployment or Worker's Comp No. of Weeks:_____ Start Date:_____End Date:_____ Per Week $:_____	$	$
Other Income (Stocks/Bonds/Annuities/Interest/Rental Property)	$	$
Other Income (from family, friends, church, etc…)	$	$

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VERIFICATION OF INCOME AND IDENTIFICATION

If we need additional information, you will be notified by telephone, US Mail or e-mail.

I certify that all information is true and complete to the best of my knowledge. I understand that the information provided will be verified and treated as personal and confidential. I authorize the release of any and all information from the California Department of Health Care Services. **I understand that I must provide verification of income, expenses, dependents, bank statements, pay vouchers and tax statements if applicable.** I also understand that I will be liable for payment of any services rendered at Fresno Surgical Hospital if the above information is given under false pretenses. I know that I am asking for financial assistance from Fresno Surgical Hospital only and not from other health care providers or physicians.

SIGNATURE: **DATE:**

SPOUSE SIGNATURE (if applicable) **DATE:**