



## APPLICATION FOR FINANCIAL ASSISTANCE

This is an application for the Sponsored Care and Discount Payment programs, designed to provide financial assistance to those who cannot afford care from MoGo Urgent Care.

To be considered for financial assistance, a completed application must be submitted to our office no later than 30 days from the service date. Incomplete applications will be kept on file until all information is received.

Mail completed applications to 40 Ryan Court, Suite 100, Monterey, CA 93940. Please be sure to attach required documentation as indicated on the application.

If you apply and are deemed eligible by MoGo Urgent, you will be notified of the discount amount for which you have been approved.

If you have questions regarding the completion of your application, please call Patient Business Services at (831) 625-4922.

# APPLICATION TO DETERMINE SPONSORED CARE OR DISCOUNT PAYMENT PROGRAM ELIGIBILITY

This application is to be completed by the parent, legal guardian, or applicant (if independent and age 18 or older, or an emancipated minor) in order to determine if the applicant is eligible for financial assistance under MoGo Urgent Care's Sponsored Care or Discount Payment programs. The term "applicant" means the patient for whom MoGo Urgent Care provided care. Please type or print clearly.

Mail completed applications with required documentation to 40 Ryan Court, Suite 100, Monterey, CA 93940.

## Section A: APPLICANT INFORMATION

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NAME OF APPLICANT (LAST, FIRST, MIDDLE)

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ANY OTHER NAME THE APPLICANT IS KNOWN BY

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DATE OF BIRTH (MONTH/DAY/YEAR)

SOCIAL SECURITY NUMBER

### RESIDENCE ADDRESS:

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NUMBER AND STREET (DO NOT USE P. O. BOX)

CITY

STATE

ZIP

### MAILING ADDRESS (IF DIFFERENT FROM RESIDENCE):

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NUMBER AND STREET (DO NOT USE P. O. BOX)

CITY

STATE

ZIP

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CELLULAR PHONE NUMBER

ALTERNATE PHONE NUMBER

What language do you speak at home? \_\_\_\_\_

The sponsored care and discount payment programs require submission of the following documentation:

- Completed application form
- Proof of income
  - Copy of signed tax return from the most recent tax year, or
  - Pay stubs from the past 3 months, for all members of the family

You may be asked to provide additional documentation, including but not limited to the following:

- Proof of out-of-pocket medical, dental, pharmacy, and insurance premium expenses, such as receipts
- Additional documentation as evidence of lack of income

## Section B: PARENTAL/LEGAL GUARDIAN INFORMATION

(Applicants age 18 or older or emancipated minors skip to Section C)

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NAME(S) OF PARENT OR LEGAL GUARDIAN

RELATIONSHIP

### RESIDENCE ADDRESS:

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NUMBER AND STREET (DO NOT USE P. O. BOX)

CITY

STATE

ZIP

### MAILING ADDRESS (IF DIFFERENT FROM RESIDENCE):

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NUMBER AND STREET (DO NOT USE P. O. BOX)

CITY

STATE

ZIP

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CELLULAR NUMBER

ALTERNATE PHONE NUMBER

MESSAGE PHONE NUMBER

**Section C: INCOME INFORMATION** (Report income for the following family members: spouse, domestic partner, parent, and dependent children. Attach additional sheets of information)

Number of family members (including applicant) in your home you can claim on your income tax: \_\_\_\_\_

NAME OF FAMILY MEMBER	EMPLOYER	STUDENT STATUS YES OR NO FULL-TIME OR PART-TIME	GROSS INCOME FOR LAST 12 MONTHS	INCOME MOST RECENT TAX YEAR

**Section D: ASSET INFORMATION** (Complete this section only if you are applying for the Sponsored Care Program because of high medical costs)

Report current value of your monetary assets. Attach additional sheets if necessary.

**Supporting documents may be required.**

	VALUE	ACCOUNT NUMBER	NAME/ADDRESS OF INSTITUTION
CASH			
CHECKING ACCOUNT			
SAVINGS ACCOUNT			
CERTIFICATE OF DEPOSIT			
BROKERAGE ACCOUNT			
NON-TAX-DEFERRED SECURITIES AND INVESTMENTS			
PRECIOUS METALS/JEWELRY			
ASSETS HELD IN TRUST			
OTHER MONETARY ASSETS			

\_\_\_\_\_  
INITIAL HERE I am applying for the MoGo Urgent Care's Sponsored Care or Discount Program as indicated above.

I understand that failure to provide requested information by the due date will result in denial of my application.

\_\_\_\_\_  
INITIAL HERE I certify that I have read and understand the information on this application.

\_\_\_\_\_  
INITIAL HERE I certify that the information I have given on this form is true and correct.

\_\_\_\_\_  
INITIAL HERE If I am applying for Sponsored Care, I understand and agree that MoGo Urgent Care will run a credit report on me and may also verify my employment and property ownership.

**Additional comments:**

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APPLICANT'S SIGNATURE

\_\_\_\_\_  
TODAY'S DATE