

H.A.: M.Cal Pending Date	DOS:
Balance: \$	NPC



Application for Financial Assistance

Please answer all questions. If not applicable, please write N/A.

For Office Use Only

1. Patient Account Number	2. Patient Medical Record Number
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Section I

3. Patient Name		
4. Date of Birth	5. Social Security Number	
6. Street Address/Apartment Number		
City	State	Zip Code
Phone Number	Phone Number	
7. Drivers License Number		

8. a. Have you applied for Medi-Cal or AFDC?	<input type="checkbox"/> yes	<input type="checkbox"/> no
If yes, date of application:		
If yes, name of worker:		

b. Do you have an application pending?	<input type="checkbox"/> yes	<input type="checkbox"/> no
c. Has your application been denied?	<input type="checkbox"/> yes	<input type="checkbox"/> no
9. Are you under 21 years of age?	<input type="checkbox"/> yes	<input type="checkbox"/> no
10. Are you 65 years of age or older?	<input type="checkbox"/> yes	<input type="checkbox"/> no
11. Are you legally blind?	<input type="checkbox"/> yes	<input type="checkbox"/> no
12. Are you pregnant?	<input type="checkbox"/> yes	<input type="checkbox"/> no
13. Are you now unable, or do you expect to be unable to work for one year or longer?	<input type="checkbox"/> yes	<input type="checkbox"/> no
14. Do you have a minor child under the age of 21 in your home?	<input type="checkbox"/> yes	<input type="checkbox"/> no
15. Are you a student?	<input type="checkbox"/> yes	<input type="checkbox"/> no
16. Do you have Medicare?	<input type="checkbox"/> yes	<input type="checkbox"/> no
17. Do you live in a nursing home?	<input type="checkbox"/> yes	<input type="checkbox"/> no
18. Do you have health insurance?	<input type="checkbox"/> yes	<input type="checkbox"/> no
19. Are you a Veteran or the dependent of a Veteran?	<input type="checkbox"/> yes	<input type="checkbox"/> no
a. Do you have CHAMPUS?	<input type="checkbox"/> yes	<input type="checkbox"/> no
b. Do you have CHAMP/VA?	<input type="checkbox"/> yes	<input type="checkbox"/> no

Section II (Assets/Budget)

20. What is the current balance of your Savings Account? \$			
21. What is the current balance of your Checking Account? \$			
22. Other Assets (if none, please leave blank)	YES	NO	VALUE
Rental Property			\$
Other Assets			\$
Other Assets			\$
<u>Monthly Income</u>	<u>Amount</u>	<u>Source of Income (job, SSI, etc.)</u>	
23. Self	\$		
24. Spouse	\$		
25. Other	\$		
Other	\$		
26. Total Gross Income (before taxes) \$			
27. If no income, how do you support yourself?			
28. Do you live alone? <input type="checkbox"/> YES <input type="checkbox"/> NO			
29. Residence Type House Apartment Shelter Other			
30. How many exemptions do you claim on your Income Tax return, including yourself?			

I declare under the penalty of perjury that all information given is true and correct to the best of my knowledge and belief. I agree to notify this hospital of any changes in my financial circumstances and to provide upon request, information verifying my eligibility status. This information may be released to your physician.

Signature	Date
Representative	Date
Interviewer	Date
Comments	

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32. Does patient meet indigent income levels for Financial Assistance YES NO

Approved for Financial Assistance

Signature

Date