

## **CHARITY CARE POLICY**

## EXHIBIT B

# APPLICATION FOR CHARITY CARE

**\*If there are additi**

application.

An ALAMEDA HEALTH SYSTEM Affiliate

## INCOME VERIFICATION

How are you paid? Answer the following income questions for patient and spouse if applicable. The income verification process requires proof of income documents.

Acceptable proof of income documents include: Most recent tax return, 2 most recent check stubs, a letter from employer stating earned wages, a perjury statement or proof of unemployment.

Type of Income	Amount	How often (Circle One)
Employment: Patient/Guarantor		Weekly/ Bi-weekly/ Monthly/ Other
Employment: Spouse		Weekly/ Bi-weekly/ Monthly/ Other
Cash Income: Patient/Guarantor		Weekly/ Bi-weekly/ Monthly/ Other
Cash Income: Spouse		Weekly/ Bi-weekly/ Monthly/ Other
Unemployment: Patient/Guarantor		Weekly/ Bi-weekly/ Monthly/ Other
Unemployment: Spouse		Weekly/ Bi-weekly/ Monthly/ Other
Disability: Patient/Guarantor		Weekly/ Bi-weekly/ Monthly/ Other
Disability: Spouse		Weekly/ Bi-weekly/ Monthly/ Other
Social Security: Patient/Guarantor		Weekly/ Bi-weekly/ Monthly/ Other
Social Security: Spouse		Weekly/ Bi-weekly/ Monthly/ Other
Workers Comp: Patient/Guarantor		Weekly/ Bi-weekly/ Monthly/ Other
Workers Comp: Spouse		Weekly/ Bi-weekly/ Monthly/ Other
Child Support: Patient/Guarantor		Weekly/ Bi-weekly/ Monthly/ Other
Child Support: Spouse		Weekly/ Bi-weekly/ Monthly/ Other
Other Income:		Weekly/ Bi-weekly/ Monthly/ Other
Other Income:		Weekly/ Bi-weekly/ Monthly/ Other
Other Income:		Weekly/ Bi-weekly/ Monthly/ Other
<b>Total Monthly Income:</b>		

### Patient Acknowledgement Statement

I certify that the information that I have provided is accurate and complete to the best of my knowledge and in the event of a change in income or insurance, I will contact/notify the facility. I understand that upon submission of this application, it will be screened for free charity care eligibility. I understand that if it is determined that I qualify to receive free charity care; I will not be financially responsible for any portion of my care.

\_\_\_\_\_  
Patient/Guarantor Signature

\_\_\_\_\_  
Date

**Self-Declaration of Income (Must be completed if you do not have proof of income)**

Please complete the information below **only if you have no other way to document** your income. All of the boxes must be checked, and all questions answered. Failure to complete this information will result in a denial of your application for discounted care.

I get paid in cash  
 I do not receive pay checks/pay stubs.  
 I cannot provide a letter from my employer.

Explain why: \_\_\_\_\_

I do not have access to my financial information.

Explain why: \_\_\_\_\_

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**Patient Certification Statement**

I certify that I have no other way to document my income and that all above information is accurate. I understand that this information is to be used to determine eligibility for St. Rose Hospital free Charity Care. I understand that St. Rose Hospital officials may verify information on this form.

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Patient signature

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Date

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**Employee Certification Acknowledgement**

I certify that I have asked the applicant for proof of all sources of income received by the household prior to using this form. I made an effort to secure all other possible sources of income documentation. The information reported on this form was provided solely by the applicant and reflects accurately the household income as reported to me by the applicant.

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Employee Signature

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Date

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### **Additional Dependent Information**

Please use this space to document dependents that are not already recorded in the space provided on page 2.

Name	Age	Relationship to patient