27200 Calaroga Ave, Hayward, CA 94545

Financial Assistance / Charity Care Policy	EXHIBIT B

STATEMENT OF FINANCIAL CONDITION/FINANCIAL ASSISTANCE APPLICATION

PATIENT NAME _____ SPOUSE _____

ADDRESS _____

PHONE _____ SSN: _____

ACCOUNT # _____

FAMILY STATUS: List all dependents that you support

Name	Age	Relationship (PATIENT)	Relationship (SPOUSE)

EMPLOYMENT AND OCCUPATION

Employer: _____ Position: _____

Contact Person & Telephone Number: _____

If Self-Employed the Name of Business: _____

Spouse Employer: _____ Position: _____

Contact Person & Telephone Number: _____

If Self-Employed, Name of Business: _____

CURRENT MONTHLY INCOME

		Patient	Spouse
	Gross Pay(Before Deductions)		
Add:	Income from Operating Business (ifSelf-Employed)		
Add:	Other Income		
	Interest&Dividends		
	From RealEstate		
	Social Security		
	Other (Specify)		
	Alimony or Spousal Support		
Subtract:	Alimony, Support Payments Paid		
Equals	Current Monthly Income		

Total Current Monthly Income (Patient & Spouse) = $_____

FAMILY SIZE

Total Family Members: _____
(add patient, spouse and dependents from above)

	Yes	No
Do you have health insurance?		
Are you eligible for any government programs?		
Do you have other insurance that may apply (such as auto policy)?		
Were your injuries caused by a third party? (such as during car accident)?		

By signing this form, I agree to allow St .Rose Hospital to check employment status and credit history for the purpose of determining my eligibility for financial assistance. I understand that I will be required to provide proof of the information I am providing.

_____ _____

(Signature of Patient or Guarantor) (Signature of Spouse) Date