Alvarado Parkway Institute Behavioral Health System

Charity Application (Financial Disclosure Form)

Instructions

1. To be considered and qualify for financial assistance, complete this application, and mail it to: Alvarado Parkway Institute, 7050 Parkway Drive, La Mesa, CA 91942, Attn: Director of Patient Accounts or fax to (619) 667-6054.
2. Patients may call the Business Office at (619) 667-6187 for more information on financial assistance and/or assistance with the application process.

RESPONSIBLE PARTY:	
LAST NAME:	FIRST NAME, MIDDLE INITIAL
PATIENT NAME (if other than responsible party)	PATIENT ACCOUNT #
SPOUSE FULL NAME	NUMBER OF DEPENDENTS
STREET ADDRESS	HOME PHONE
CITY, STATE, POSTAL ZONE	WORK PHONE
EMERGENCY PHONE #/RESPONSIBLE PARTY DATE OF BIRTH	RESPONSIBLE PARTY SOCIAL SECURITY #
RESPONSIBLE PARTY	**SPOUSE**
OCCUPATION	OCCUPATION
EMPLOYER (IF SELF EMPLOYED, DESCRIBE BUSINESS)	EMPLOYER (IF SELF EMPLOYED, DESCRIBE BUSINESS)
EMPLOYER ADDRESS	EMPLOYER ADDRESS
SUPERVISOR'S NAME	SUPERVISOR'S NAME
PHONE NUMBER YEARS AT PRESENT JOB	PHONE NUMBER/ YEARS AT PRESENT JOB
SALARY $ HOURLY $	SALARY $ HOURLY $
BIWEEKLY $ MONTHLY $	BIWEEKLY $ MONTHLY $
OTHER INCOME $ SOURCE	OTHER INCOME $ SOURCE
ASSETS	**LIABILITIES**
CASH ON HAND: $	REAL-ESTATE PAYMENTS: $
CHECKING ACCOUNT BALANCE: $	INS. PREMIUMS (AUTO, HOME, MEDICAL): $
SAVINGS ACCOUNT BALANCE: $	TAXES: $
CREDIT UNION ACT BALANCE: $	UTILITIES: $
PROPERTY OWNED VALUE: $	AUTO PAYMENTS: $
HOME (IF OWNED) VALUE: $	RENTAL PAYMENT (HOME/APT): $

VEHICLE(S) ESTIMATED VALUE: $	OTHER LIABILITIES
MAKE:	(PROVIDE DESCRIPTION):
MODEL:	
MAKE:	
MODEL:	
TRUST ACCOUNT(S): $	
ADDITIONAL INCOME: $	
TOTAL ASSETS: $	**TOTAL LIABILITIES: $**
BANK NAME: 1. _____ 2. _____ 3. _____	BANK ACCOUNT NUMBER: 1. _____ 2. _____ 3. _____

PLEASE INCLUDE BANK STATEMENT AND LAST YEAR'S TAX RETURN

I HEREBY DECLARE THE FOREGOING IS TRUE UNDER PENALTY OF PERJURY AND UNDER THE LAWS OF THE STATE OF CALIFORNIA. I UNDERSTAND THAT A CREDIT REPORT MAY BE REQUESTED.

SIGNATURE: _____ DATE: _____