SOUTHWEST HEALTHCARE SYSTEM
INLAND VALLEY MEDICAL CENTER
RANCHO SPRINGS MEDICAL CENTER

Charity Application

Application should be returned within 21 days of receipt. When submitting your application, please provide the following information.

1. Most recent paycheck stub copy. **2.** Current month's bank statement.

3. Most recently filed tax return and W2 copy.

Your credit report will be accessed. Questions, call Customer Service at 702-894-5700.

Patient #	Hospital Name
Date of Application	Diagnosis
Date of Service	Is the Patient Deceased?
Is the Patient Homeless?	
Charity Care Requested By	
Have You Ever Applied for Medicaid or Any Other State/County Assistance? If Yes, Please List the Following:	If you have not applied for State/County assistance, why not?
	Agency Name;
Caseworker Name;	Phone Number;

If denied by Medicaid send denial letter. If approved send copy of approval letter.

I. PATIENT

Last Name First Name MI Marital Status Social Security #

Street Address

City State Zip How long at this address? Home Phone#

Are you a U.S. Citizen?

II. RESPONSIBLE PARTY

Last Name First Name MI Marital Status Social Security #

Street Address

City State Zip How long at this address? Home Phone #

Are You a U.S. Citizen? Drivers License #

Relationship to Patient

Employer's Name and Address Business Phone Length of Employment

Position/Title Hourly Rate Pay Period

Total Hours Worked Per Month (Reg/OT)

Annual Gross Income $ ___ Gross Monthly Income $ _____

Other Monthly Income Besides Employment $ _____

Total Monthly Income $ _ Total Family Monthly Income $ _____

III. SPOUSE

Last Name First Name MI Social Security #

Employer's Name and Address Business Phone Length of Employment

Position/ Title Hourly Rate $

Total Hours Worked per Month (Reg./OT) _____

Annual Income $ Gross Annual Income $

Gross Monthly Income $ Pay Period

IV. HOUSEHOLD INFORMATION (ALL PERSONS IN HOUSEHOLD INCLUDING SELF)

Name	DOB	Relationship to Responsible Party

Total Persons In Household: _____

If You or Anyone In Your Family Was Covered in the Last 6 Months but is no Longer Covered, Please List the Following:

Insurance Company Name and Address

Policy # Group # Employment Related?

Name of Policy Holder Beginning Coverage Date Name of Persons Covered

V. MISCELLANEOUS INCOME PER MONTH

Dividends, Interest $ _____ Pensions **$** _____

Public Assistance/Food Stamps $_____ Investment/Rental Income $ _____
Social Security $_____ Grants $_____
Unemployment/Workers Compensation $_____
Child Support/Alimony $_____ Other $_____
TOTAL MONTHLY MISCELLANEOUS INCOME: $ _____

VI. MISCELLANEOUS EXPENSES

Do you own or rent Housing?_____ Market Value of Home $ _____
Outstanding Balance on Home Loan $_____ Years Left on Home Loan _____
Outstanding Balance on Auto Loan $_____ Years Left on Auto Loan _____
Outstanding Balance on Medical Bills $ _____
List Monthly Expenses for following:
Rent/Mortgage $_____ Food/Clothing $_____
Insurance (Homeowners/Medical/Life/Auto/Other) $_____
Property Tax $_____ Car Payments $_____
Electric/Water/Gasoline $_____ Telephone/Cellular Phone $ _____
Alimony/Child Support $_____ Credit Cards $_____
Loans $ Medical Bills/Medications $ _____
Other (Specify) $_____
Total Monthly Miscellaneous Expenses $ _____

VII. MONTHLY NET INCOME

Responsible Party's Monthly Income $ _____
Spouse's Monthly Income (If Applicable) + $ _____
Total Monthly Miscellaneous Income + $ _____
Total Monthly Miscellaneous Expenses - $ _____
Total Monthly Net Income = $ _____

VIII. ASSETS/EQUITY

List Checking Bank Name, Bank Address, Account Numbers and Average Balances;

_____

_____

List Savings Bank Name, Bank Address, Account Numbers and Average Balances;

_____

_____

Is treatment related to a third party liability claim? _____
If yes; do you have an attorney? _____
Attorney name, address, phone number:

_____

_____

List Dollar Value for the Following:
Checking Account(s) $_____ Home $_____
Other Real Estate $_____ CDs/Investments/IRA(s) $_____
Savings Account(s) $_____ Trust Funds $ _____
Life Insurance Cash Value $ _____ Motorhome(s)/Boat $ _____

Motorcycle $_____ Other Cash Value $_____

Automobile(s) $

Make: _____

Model:

Year: _____

List Other Assets: _____

Total Equities: $ _____

IX. COMMENTS

_____

_____

_____

_____

Applicant Signature: _____ Date: _____

Responsible Party Signature: _____ Date: _____

Hospital Representative Signature _____ Date: _____

Please return application and all required documents to:
UHS Western Region CBO
Customer Service Dept
2700 Fire Mesa St
Las Vegas, NV 89128
Ph: 866-823-4250

Or by facsimile:
702-360-5071