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

Washington Hospital Healthcare System

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

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?	☐ yes	☐ no
	If yes, date of application:		
	If yes, name of worker:		
	b. Do you have an application pending?	☐ yes	☐ no
	c. Has your application been denied?	☐ yes	☐ no
9.	Are you under 21 years of age?	☐ yes	☐ no
10.	Are you 65 years of age or older?	☐ yes	☐ no
11.	Are you legally blind?	☐ yes	☐ no
12.	Are you pregnant?	☐ yes	☐ no
13.	Are you now unable, or do you expect to be unable to work for one year or longer?	☐ yes	☐ no
14.	Do you have a minor child under the age of 21 in your home?	☐ yes	☐ no
15.	Are you a student?	☐ yes	☐ no
16.	Do you have Medicare?	☐ yes	☐ no
17.	Do you live in a nursing home?	☐ yes	☐ no
18.	Do you have health insurance?	☐ yes	☐ no
19.	Are you a Veteran or the dependent of a Veteran?	☐ yes	☐ no
	a. Do you have CHAMPUS?	☐ yes	☐ no
	b. Do you have CHAMP/VA?	☐ yes	☐ 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			$
Monthly Income	Amount	Source of Income (job, SSI, etc.)	
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? ☐ YES ☐ 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	

For Office Use Only

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

Approved for Financial Assistance

_____ _____

Signature *Date*