Del Amo Hospital
23700 Camino Del Sol
Torrance, California 90505
Telephone: (310) 530-1151

Dear Date:

I am sending you this letter to assist you with your account at Del Amo Hospital. Enclosed is a copy of our Application for Discount or Charity for your stay for dates of service: _____.

Our hospital has a Charity & Discount program available to all patients. You will continue to be billed for your stay at Del Amo Hospital until your application has been received in our office. We will need supporting documentation with your signed Application for Discount or Charity in order to review your case.

Supporting documentation for Charity or Discount should be one of the following:

- **A copy of recent paystubs within a 6-month period before or after the patient's hospital stay**
- **Income tax return for year in which patient was first billed or 12 months prior to the patient's hospital stay**

If you do not wish to apply for the Charity & Discount please remit your payment today to:

Del Amo Hospital
23700 Camino Del Sol
Att: Business Office
Torrance, Ca 90505

If you should have any questions, please feel free to contact me at 310-530-1151

Thank you in advance for your time in this matter.
Respectfully,

Del Amo Hospital
Business Office
Cc: File
Financial Disclosure Form

Del Amo Hospital
23700 Camino Del Sol
Torrance, CA 90505

Patient No: _____
Admit Date: _____
Date completed: _____
Approval: _____

THIS FORM IS TO BE COMPLETED BY PERSON RESPONSIBLE FOR BILL

The information requested is to allow us to assist you in establishing a reasonable payment program and is confidential.

PATIENT:

1. Name: SSN:

2. Address:

Street City

State Zip

3. Employment:

Employer Phone Number

Street City

Years of employment

4. Are you disabled? _____ If yes, disability:

RESPONSIBLE PARTY:

5. Name: SSN:

6. Address:

Street City

State Zip

7. Employment:

Employer Phone Number

Street City

Years of employment

8. Are you disabled? If yes, disability:

DEPENDENTS OF RESPONSIBLE PARTY (SPOUSE):

9. Name: SSN:

10. Address:

Street City

State Zip

11. Employment:

Employer Phone Number

Street City

Years of employment

12. Are you disabled? If yes, disability:

DEPENDENTS OTHER THAN SPOUSE FOR WHICH YOU PROVIDE FOOD AND SHELTER:

13. Ages:
14. Are any of the above dependents employed? _____ Where?
15. Are any of the above dependents disabled? _____ Disability:
16. Which of the above dependents do not live with you?
17. Why?

INSURANCE:

18. Is the above patient covered by any health insurance through an employer or private plan?

☐ Y ☐ N

If yes, name the primary insurance:

Benefits coverage:

Name of Secondary insurance:

Benefits coverage:

RESPONSIBLE PARTIES FINANCIAL INFORMATION

17. Present Employer(s) All Sources	Occupation	Work Phone	Monthly Gross Pay	Monthly Take Home	Years On Job
a)					
b)					
c)					
d)					

Please List Any Other Financial Conditions Which Should Be Considered in Establishing a Payment Plan: _____

_____

_____

_____

In order to receive free or discounted healthcare, you must cooperate fully with our need for accurate and detailed financial information, including the timely production of necessary documentation to support this application for financial need. Completion of this application does not guarantee that you will be eligible to receive free or discounted healthcare.

I hereby authorize representatives of **Del Amo Hospital**, its affiliates and their respective agents and employees to make whatever inquires necessary to verify the information furnished on this form, or to release any information regarding this treatment and/or hospitalization to any insurance company or third party to seek settlement of this account. I hereby state that to the best of my knowledge the information given above is true and complete. I agree to notify **Del Amo Hospital** of any material changes in my financial situation. I further authorize **Del Amo Hospital** its affiliates and their respective agents and employees to review and/or inquire into my credit history using any means available to obtain a current Credit Bureau History Report.

Date Signed

Witness Spouse

For additional information or questions, you may contact ***Del Amo Business Office Representative:***

Name_____telephone #_____