LADMC LA DOWNTOWN MEDICAL CENTER LLC

CHARITY CARE APPLICATION

Request for Uncompensated Services

Account# Date of Service:

Name:
First Middle Last

Address:
Number/Street City State Zip

Telephone (

Sex Code 1-Male 2-Female

Date of Birth:

Ethnicity: Enter ethnicity code as follows:

(1) White
(2) Black
(3) Hispanic
(4) Native American/Eskimo
(5) Asian/Pacific Islander
(6) Other

Family Size:

Name •

Family Principal Income Source:

Code:

(01) Professional technical Employment
(02) Labor/Production Employment
(03) Agricultural Employment
(04) Service/Sales Employment
(05) Unemployment Compensation
(06) Retirement Income
(07) Disability Income
(08) General Relief
(09) Other Income Source
(10) None

Potential 3rd Party Payor Source:

Code:

(1) Private Insurance
(2) Medi-Cal
(3) Medicare
(4) Self-Pay
(5) Other
(6) None

INCOME: List Income for family from:	MONTHLY	ANNUAL
Wages (Self)		
(Spouse)		
(other Family Members)		
Farm or self-employed		
Public Assistance		
Social Security		
Unemployrnent-compensation----		
Worker's Compensation		
Strike Benefits		
Alimony		
Child Support		
Military Family Allotments		
Pensions		
Income from Dividends, Interest, Rent		

TYPE OF SERVICE: Code: _____

(1) Hospital Inpatient
(2) Hospital Outpatient
(3) Hospital Emergency Room

UNITS OF SERVICE:

I/P Days _____
O/P Visits _____
E/P Visits _____

Billed Amount $_____

Repayment Collected $_____

Other Write-Offs $_____

Patient Liability $_____

Date of Service: _____

Expenses (Monthly)

Mortgage/Rent	$ _____
Medical Insurance	$ _____
Utilities	$ _____
Auto Insurance	$ _____
Telephone	$ _____
Medical Bills	$ _____
Food	$ _____
Hospital	$ _____
Finance Companies	$ _____
Physicians	$ _____
Credit Union	$ _____
Medications	$ _____
Auto Loans	$ _____
Total Expenses:	$ _____

Net Worth

Do you own your home?) Yes) No

If yes, estimate value: _____
Less outstanding owed: _____
Net Value: _____

Do you own other property? ( ) Yes) No

If yes, estimate value: _____
Less outstanding owed: _____
Net Value: _____

Do you own automobile? ( )Yes) No

Amount _____Net_____

Model/Make Year	Value Owed	Value
_____	_____	_____
_____	_____	_____
_____	_____	_____

BANK REFERENCES:

Name/Branch: _____ Account# _____

Name/Branch: _____ Account# _____

Total Net value of all items in this section: _____

Liability Computation

Plus Total Monthly Gross Income (A)_____Adjusted Net Monthly

Minus Monthly Deductions (B)_____

Income A-B_____

I declare under penalty of perjury that the answers I have given are true and correct to the best of my knowledge

I agree to tell the provider of service within ten (10) days of there are any changes in my (or the persons on whose behalf I am acting) income, property, expenses or in the persons in the household or any change of address.

I understand the county is required by law to keep any information I provide confidential.

I further agree, that in consideration for receiving health care services as a result of an accident or injury, to reimburse the county from the proceeds of any litigation or settlement resulting from such act.

Signature _____ Date _____

For Hospital Use Only: _____Accepted _____Denied

Comments:

Signature _____ Date _____