

Gateways Hospital and Mental Health Center

CHARITY / DISCOUNT CARE ELIGIBILITY DETERMINATION

GENERAL					
Guarantor Name:					
Address:					
City:	State:	Zip:	Country:		
Phone ()		How Long at this address?			
Method of Verification:	<input type="checkbox"/> Power bill	<input type="checkbox"/> Water bill	<input type="checkbox"/> Drivers License	<input type="checkbox"/> Other	
Previous Address:					
Eligibility Requirements for Charity or Discout Care					
Social Security Number:			Date of Birth:		
Place of Employment:					
Length of Employment:					
if not employed, what is your source of income?					
Gross income per month:			Number of dependents:		
Spouse's Name:					
Spouse's Place of Employment:					
How long:					
Gross income per month:			Total Gross Income per month:		
Verified by tax return: (year)			Do you have health insurance?		
If so what type of insurance and with whom?					
Effective Date:			Is a copy of card available?		
MEDICAL ELIGIBILITY					
Have you applied for Medi-cal or any other government assistance Y or N If so when?					
Were you denied assistance? Y or N If denied why?					
Applicants Signature:				Date:	
Applicants Signature:				Date:	