Barstow Community Hospital
Charity Care/ Financial Assistance Program Application

Patient Account Number: _____ **Date of Application:** _____

PATIENT INFORMATION

Name_____
Address_____
City_____
State/ZIP_____
SS#_____
Employer_____
Address_____
City_____
State/Zip_____
Work Phone_____
Length of Employment_____
Supervisor_____

PARENT/GUARANTOR/SPOUSE

Name_____
Address_____
City_____
State/Zip_____
SS#_____
Employer_____
Address_____
City_____
State/Zip_____
Work Phone_____
Length of Employment_____
Supervisor_____

RESOURCES

Checking: YES ☐ NO ☐
Savings: YES ☐ NO ☐
Cash on hand: $_____

Vehicle 1: Yr_____ Make_____ Model_____
Vehicle 2: Yr_____ Make_____ Model_____
Vehicle 3: Yr_____ Make_____ Model_____

Charity Care/ Financial Assistance Program Application

INCOME

Patient/ Guarantor:
Wages (monthly):_____

Spouse/ Second Parent:
Wages (monthly):_____

OTHER INCOME		**OTHER INCOME**	
Child Support:	$_____	Child Support:	$_____
VA Benefits:	$_____	VA Benefits:	$_____
Workers' Comp:	$_____	Workers' Comp:	$_____
SSI:	$_____	SSI:	$_____
Other:	$_____	Other:	$_____

LIVING ARRANGEMENTS

Rent: _____ Own: _____Other (explain) _____

Landlord/Mortgage Holder: _____

Phone Number _____ Monthly payment $_____

REQUIRED DOCUMENTS

The following documents must be attached to process your application for Charity Care/Financial Assistance:

- Proof of Income: Prior year income tax return, last 3 months bank statements, last 4 check stubs (if applicable), or a letter from employer, or letter from Social Security, etc.
- Proof of Expenses: Copy of mortgage payment or rental agreement, copies of all monthly bills (including credit cards, bank loans, car loans, insurance payments, utilities, cable and sell phones.)
- Other documents as requested.

*The information provided in this application is subject to verification by the hospital and has been provided to determine my ability to pay my debt. I understand that any false information provided by me will result in denial of any financial assistance by the hospital.

**The hospital reserves the right to pull a copy of your credit report.*

Signature of Applicant_____

Hospital Representative Completing Application_____

***The below signatures are an indication of your review of the application and supporting documentation and that you find the information to meet policy requirements.**

Approval/ Authorization of Charity Write-Off

$_____

Amount Approved:

CEO_____

BOM_____

CFO_____