Financial Assistance Application
INSTRUCTIONS

1. Please complete all areas on the attached application form.
    a. If any area does not apply to you, write N/A in the space provided.
2. Attach an additional page if you need more space to answer any question.
3. Proof of income is required when you submit this application. The following documents are accepted as proof of income:
    a. Two (2) paycheck stubs to only one of the following:
        i. Within six (6) months prior to being first billed or
        ii. within six (6) months after first billed or
        iii. in cases of prior to admission six months prior to submitted application.
    b. Federal Tax Return and/or W-2 Form showing wages and earnings for the year in which you (patient) are being billed for services or 12 months prior to when you (patient) were first billed
    c. Social Security Monthly Income Statement;
    d. If you are paid only in cash, please provide a written statement explaining your income sources.
    e. If you have no income, please complete and initial the NO INCOME AFFIDIVIT on page 2 of the application.
4. It is important that you complete, sign and submit the financial assistance application along with all required attachments.
5. You must sign and date the application.
6. **Your application cannot be processed until all required information is provided.**

Your completed application can be <u>mailed</u> or <u>emailed</u> to the addresses below:

College Hospitals, PO BOX 2104, Santa Fe Springs, Ca 90670 or charitycare@chc.la

If you have questions, please call your account representative at (562) 904-3998

College Hospital Patient Financial Assistance Application

All persons are prohibited from giving to any hospital in this state a false or fictitious name, a false or fictitious address, or any other false or fictitious information that is required to be obtained by such hospital in compliance with state and federal laws. All persons are also prohibited from assigning to any hospital the proceeds of any insurance contract, then knowing that such contract is no longer in force or is invalid or is void for any reason. Such action shall be evidence of the intent of such persons to defraud such hospital.

Application Type (select one): ☐ Charity (Free Care) ☐ Discount Program

Patient Information –

Patient Name:	DOB:	Social Security Number: - -
Patient Address: (if homeless, please complete affidavit on bottom of page 2)		Home/Cell Phone Number: ( ) -

Medical Assistance Screening –

Family Services:

Is the patient eligible for Medi-Cal? [ ] Yes [ ] No
Is the patient a veteran? [ ] Yes [ ] No
Has the patient ever applied for Medi-Cal? [ ] Yes [ ] No
If yes, do you have a service connected disability? [ ] Yes [ ] No
Is the patient a victim of crime? [ ] Yes [ ] No
Do you have a claim number? [ ] Yes [ ] No
If yes, please provide the case number:_____

Responsible Party/Guarantor - To determine qualifications for any discounts or assistance programs the following information must be completed.

Responsible Party/Guarantor Name:	DOB:	Social Security Number: - -
Address:		Home/Cell Phone Number: ( ) -
Residence Status: [ ] Rent [ ] Own	Length at Residence:	Marital Status (check one) [ ] Married [ ] Single [ ] Divorced [ ] Separated
Employment Status: [ ] Unemployed [ ] Retired [ ] Disabled [ ] Employed Full-Time (Min 32 hours per week) [ ] Employed Part-Time (less than 32 hours per week		
Employer Name	Employer Address:	Employer Telephone Number:

Dependents - Household Members (All persons living in the home excluding patient/guarantor)

Name:	Age:	Relationship:	Amount Contributed to Household:

Family Income - list all sources of income received

Current **Monthly** Income:		
	Patient/Guarantor	Spouse
Gross Wages & Salary (before deductions)	$	$
Self-Employment Income	$	$
Interest & Dividends	$	$
Real Estate Rental & Lease	$	$
Social Security Income / Social Security Disability	$	$
Alimony	$	$
Child Support	$	$
Unemployment / Disability	$	$
Public Assistance (i.e. food stamps, etc.)	$	$
All other sources (attach list)	$	$

Proof of income is required: (a) Two most recent paycheck stubs or (b) W2 showing wages/earnings

NO INCOME AFFIDAVIT – Must initial the statement below.

I, _____, herby certify that I have no job or assets, and no income other than potential donations from others. Parent/Guarantor **Initials** _____

Expenses – list additional expenses in blanks below (attach list)

List Expenses:	Monthly Payment:	Balance Due:
Monthly Rent/Mortgage		
Automobile Payment		
Automobile Insurance		

HOMELESS AFFIDAVIT – If homeless, must initial the statement below.

I, _____, herby certify that I am homeless, have no permanent address, no job or assets, and no income other than potential donations from others. Parent/Guarantor **Initials** _____

Attestation of Truth - I hereby acknowledge all of the information provided herein is true and correct. I understand that providing false information will result in the denial of the application. Additionally, depending upon local or state statutes, providing false information to defraud a hospital for obtaining goods or services may be considered an unlawful act. I also acknowledge and consent that a credit report will be obtained, or other such measures may be taken to verify information provided herein. I fully understand that College Hospital Charity Care program(s) is a payer of last resort and hereby confirm all prior assignments of benefits and rights, which include liability actions, personal injury claims, settlements, and any and all insurance benefits, provided to College Hospital.

_____ _____

Signature Date