BHC Alhambra Hospital
4619 N. Rosemead Blvd.
Rosemead, CA 91770
Telephone: (626) 286-1191

Dear Date:

I am sending you this letter to assist you with your account here at BHC Alhambra Hospital. Included is a copy of our Charity Care Application (Financial Disclosure Form) for your stay for dates of service: _____ due to limited or no insurance coverage.

Our hospital has a Charity & Discount program available to all patients. You will continue to be billed for your stay here at BHC Alhambra Hospital until your application has been received in our office. We will need supporting documentation with your signed Financial Disclosure Form in order to review your application.

Supporting documentation for income, **required** to be submitted with the application:

- A copy of two paychecks/paystubs (if applicable), dated within a 6-month period before or after you were first billed by the hospital, OR income Tax Return for 20___ - that documents income for the year in which you were first billed or 12 months prior to when you were first billed

Supporting documentation for income, **not required** but may help assist with our review:

- A copy of W-2's (if applicable), matching the time period above for income tax returns
- Statement from employer (if applicable, when paychecks or W-2's cannot be obtained)
- SSI Statement of Earnings (if applicable)
- List and proof of paid Medical expenses (EOMB's, cancelled checks, statements, receipts)
- Any additional information you feel will help with our review

The application is the same for a Discount or for Charity. The information provided will assist the hospital in determining whether you qualify for either program. Patients who are eligible for the discounted payment may receive less financial assistance than what may be available to them under the charity care program.

If you do not wish to apply for these programs, please remit your payment today to the address above, attention Business Office. If you have any questions, please contact the hospital Business Office at (626) 286-1191.

Thank you in advance for your time and attention to your hospital account.

Respectfully,

BHC Alhambra Hospital
Business Office
Cc: File

BHC Alhambra Hospital

Visiting Hours
Youth Services Mon-Sun 05:30 pm – 06:30 pm
Youth Services Mon-Sun 05:30 pm – 06:30 pm

4619 N. Rosemead Blvd.
Rosemead, CA 91770
www.bhcalhambra.com
Tel: (626) 286-1191

(Administration Use Only)

Patient#_____

Admit Date:_____

Date Completed:_____

Approval:_____

Financial Disclosure Form (Financial Assistance Application)

THIS FORM IS TO BE COMPLETED BY PERSON RESPONSIBLE FOR THE BILL

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

_____

PATIENT:

1. Name:_____ SSN:_____
   Last First Middle
2. Address:_____
   Street
   _____
   City State Zip Code
3. Employment:_____
   Employer Phone Number
4. Are you disabled? Yes / No If yes, please describe:_____
   _____
   _____

RESPONSIBLE PARTY:

5. Name:_____ SSN:_____
   Last First Middle
6. Address:_____
   Street
   _____
   City State Zip Code
7. Employment:_____
   Employer Phone Number

8. Are you disabled? Yes / No If yes, please describe:_____

_____

DEPENDENTS OF RESPONSIBLE PARTY (SPOUSE/DOMESTIC PARTNER):

9. Name:_____ SSN:_____
   Last First Middle
10. Address:_____
   Street

   _____
   City State Zip Code
11. Employment:_____
   Employer Phone Number

12. Are you disabled? Yes / No If yes, please describe:_____

_____

_____

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

13. Ages:_____
14. Are any of the above dependents employed? Yes / No If yes, where?_____

_____

15. Are any of the above dependents disabled? Yes / No 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? Yes / No

_____

If yes, name of the primary insurance:_____

Benefits Covered:_____

Name of the secondary insurance:_____

Benefits Covered:_____

RESPONSIBLE PARTYS' FINANCIAL INFORMATION

18.1 Present Employer(s) All Sources, Occupations, Work Phone, Monthly Gross Pay, Monthly Take Home, Years on the Job

(a)_____

(b)_____

(c)_____

(d)_____

_____

18.2 Any other source of income:_____ Monthly Amount_____

_____ Total Monthly Income:_____

PLEASE LIST AVAILABLE ASSETS:

CARS	$_____	CHECKING	$_____
HOMES	$_____	STOCKS/BONI	$_____
SAVINGS	$_____	LIFE INSUR.	$_____
OTHER	$_____	REAL ESTATE	$_____

19.

Monthly Expenses	Monthly Payments	Balance	Comments / Purpose
Food	$	$	
Gas / Heat	$	$	
Electric	$	$	
Water	$	$	
Telephone	$	$	
Transportation / Gas	$	$	
Rent / Mortgage	$	$	
2nd Mortgage	$	$	
Alimony	$	$	
Child Support	$	$	
Auto 1	$	$	
Auto 2	$	$	
Car Insurance	$	$	
Life Insurance	$	$	
Health Insurance	$	$	
Credit 1	$	$	
Credit 2	$	$	
Credit 3	$	$	
Bank Loan 1	$	$	
Bank Loan 2	$	$	
Finance Co. 1	$	$	
Finance Co. 2	$	$	
Other	$	$	
Other	$	$	

20. Total Monthly Expenses $_____

Please list any other financial conditions that 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 BHC Alhambra Hospital, its affiliates, and their respective agents and employees to make whatever inquiries 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 a 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 authorize BHC Alhambra Hospital of any material changes in my financial situation. I further authorize BHC Alhambra 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:_____ Signature:_____

Witness:_____ Spouse/Domestic Partner:_____

For additional information or questions, you may contact:_____