ALHAMBRA HOSPITAL Medical Center

100 South Raymond Ave., Alhambra, CA 91801

Charity Application

CONFIDENTIAL FINANCIAL STATEMENT

Patient Name: _____

Patient Number: _____

Credit Amount: _____

RESONSIBLE PARTY INFORMATION

Patient Name _____ Marital Status: _____ SS# _____

Address _____

How long at this address _____ Home Phone # _____

Employer (if unemployed-how long) _____ Work Phone # _____

Employer Address _____

Position/Title _____ Length of Emp _____

Monthly employment Income-Net $ _____

SSI: YES NO

SPOUSE

Name _____ Marital Status _____ SS# _____

Employer (if unemployed-how long) _____ Work Phone # _____

Employer Address _____

Position/Title _____ Length of Emp _____

Monthly employment Income-Net $ _____

SSI: YES NO

DEPENDENTS

List Name and Year of al persons in the household (Do any other persons contribute? How much?)

Name _____ DOB _____ Income Amount $ _____

Name _____ DOB _____ Income Amount $ _____

Name _____ DOB _____ Income Amount $ _____

Name _____ DOB _____ Income Amount $ _____

PRIMARY & OTHER INCOMES

Wages $ _____ Worker Compensation $ _____ Grants $ _____

Social Security $ _____ Child Support/allmony $ _____ IRA $ _____

Unemployment $ _____ Rental Income $ _____ Other $ _____

TOTAL INCOMES $ _____

I hereby acknowledge the above information is correct with my signature and allow ALHAMBRA HOSPITAL MEDICAL CENTER to verify this information via any agency to assist in collection of funds with settlement of the hospital bill. Any payment arrangements set up must be paid by the due date given or the outstanding balance will be assigned to a collection agency for interest to be applied. The above information will also be used for charity screening purposes.

Applicants Signature _____ Date: _____