PIH HEALTH

REQUEST FOR FINANCIAL ASSISTANCE/ UNCOMPENSATED SERVICES

12401 Washington Blvd.
Whittier, CA 90602

P: 562.698.0811
TDD: 562.696.9267

ACT: MR:

DOB:
ADM: RM:

I ask PIH Health to determine if I am eligible for help in paying for my hospital bill. I understand that I need to give certain information for this to be done. I understand that filling out this form does not guarantee that I will receive this help. If I am not eligible for uncompensated services, I am responsible for my hospital bill.

Name _____ Account Number _____
Address _____ Phone Number _____
Street City State Zip
Employer Name _____ Employer Phone # _____
Employer Address _____ Date of Birth _____
Sex Code _____ 1=Male 2=Female Number of Family Members Living with You _____

Name	Relationship	Age	Gender	Name	Relationship	Age	Gender

Physician Name _____ Diagnosis _____

PLEASE PROVIDE PHOTOCOPIES OF CHECKS AND BANK STATEMENTS, AND LIST INCOME

INCOME	Monthly	Annual		Monthly	Annual
Wages (Self)			Unemployment Compensation		
(Spouse)			Strike Benefits		
(Other Family Member)			Alimony/Child Support		
Farm or Self Employment			Military Family Allotments		
Public Assistance			Pensions		
Social Security			Income (Dividends, Interest, Rent)		

EXPENSES (Monthly)

Mortgage/Rent	_____ (1)	Medical Insurance	_____
Utilities	_____	Auto Insurance	_____
Telephone	_____	Medical Bills	_____
Food	_____	Hospital	_____
Finance/Other Loans	_____	Physician	_____
Auto Loans	_____	Medication	_____

(1) If none, source of housing _____ TOTAL EXPENSES _____

Do you own a home? ☐ Yes ☐ No If yes, estimated value _____ Amount owed _____
Do you own other property? ☐ Yes ☐ No If yes, estimated value _____
Do you own automobiles? ☐ Yes ☐ No If yes, Model/Make _____ Year ____ Value _____

- I declare under penalty of perjury that the answers I have given are true and correct to the best of my knowledge.
- I agree to tell the provider of services, within 10 days, if there are any changes in my (or the persons on whose behalf I am acting) income, property, expenses, or in the persons in the household or of any change of addresses.
- I understand that I may be asked to prove my statements and that my eligibility statements will be subject to verification by contact with my employer, bank, credit verification and property searches.
- I further agree, that in consideration for receiving health care services as a result of an accident or injury, to reimburse the county or hospital from proceeds of any litigation or settlement resulting from such act.
- I understand that if I do not qualify for uncompensated services, I will be personally liable for the charges of the services rendered by PIH Health or I may appeal decision in writing with additional documentation.

_____ _____ _____ _____
Signature Date Time Print Name

Please mail your completed application and attachments to: PIH Health P.O. Box 511216
Los Angeles, CA 90051
PIH Health Customer Service number 562.967.2875

NOT PART OF THE MEDICAL RECORD RETURN TO BUSINESS OFFICE