









## Pipeline Health - Eligibility for Patient Financial Discount (Charity) Application &

## INSTRUCTIONS

l.	All items/question on the application form must be completed for the application to be processed.					
II.	Patient signature & date is required. If guarantor/spouse provides information as well, all must sign.	Community Hospital of Huntington Park, 2623 E. Slauson Ave., Huntington Park, CA 90255, Attn: Admissions Dept.  Coast Plaza Hospital, 13100 Studebaker Road, Norwalk, CA. 90650, Attn: Admissions Dept				
•••						
III.	The attached worksheet proof of all income and supporting documentation must be received within 60 days of the initial patient billing.	East Los Angeles Doctor's Hospital, 4060 E. Whittier Blvd, Los Angeles, CA 90023, Attn: Admissions Dept.				
IV.	This application requires patient financial data.	Central Business Office, 17871 Park Plaza Dr Ste 200 Cerritos, CA 90703				
V.	The completed application & required documentation to be submitted to the applicable address are as follows:	Memorial Hospital of Gardena, 145 West Redondo Beach Blvd., Gardena, CA 90247, Attn: Admissions Dept.				
VI.	Was a federal income tax return (Form 1040) filed by patients for the most recent calendar year?	<ol> <li>The last two (2) months of any financial/ bank statements/accounts</li> <li>Yes □No □ N/A □</li> </ol>				
	Yes    No	4. If there is no patient income, documentation provided detailing how patient supports self/				
	If yes, a copy of the IRS return including All page's schedules <u>must</u> be submitted and is attached.	/family.  Yes, □ No □N/A□				
	Yes  No					
	If no patient did not file a federal income tax return, the following items <u>must</u> be provided:					
	<ol> <li>A statement explaining why patients did not file a federal tax return.</li> <li>Yes No </li> </ol>					
	2. Two (2) most recent pay stubs from patient & family members residing in same household.  Yes No					

	Name	Age	Relationship
L			
С		s and under, wh	partner, and dependent nether living at home or no if Disabled.
Χ.	Responsible	Party/ Guaran	tor Information
1.	Relationship	to Patient:	
2.	Guarantor Na	ıme	
3.	Guarantor SS	SN:	
4.	Guarantor DC	DB:	
5.	Guarantor Ph	one:	
6.	Guarantor Ho	ome Address:	
7.		nployer Name & ve name of bus	& Address: (If self- iness)
8.	Position:		
9.		. (1)	

10. Work Phone:

VII.	Does the patient currently have health
	insurance?

If yes, what insurance does the Patient have?

Patient Name:

VIII. Patient Information:

IX.

3.

2.	Patient SSN (Acct.):		
3.	Patient Date of Birth		
4.	Patient Home Phone #		
5.	Patient Work Phone #		
6.	Patient Address:		
7.	Treating Facility:		
8.	Date of Service:		
Patient Family Household Information			
1.	Spouse Name		

4. List same household family members below\*:

Spouse SSN: \_\_\_\_\_-

Spouse Birth Date:

		injury or	auto acc		ed (e.g., a work	related
XI. Homeless Affidavit		Yes		No		
Patients are currently homeless:	7	7. If yes, please provide the page	arty responsib	le for		
Yes No 🗆	_	covering the losses (e.g., in contact phone number, etc.				er, claim #,
I, (Insert Signature),	_					
hereby certify that I am homeless, have no permanent	_					
address, no job, savings or assets, and no income other						
than potential donations from others.						
<ul><li>XII. Insurance (Third Party Payer) Information</li><li>1. Patients have applied for Medi-Cal or any other income-based/means evaluated government-</li></ul>	XIII.		al Works rrent Inc			
sponsored coverage in the last 12 months?		Туре			Patient/	Spouse
Yes No No					Guarantor	
		.Gross Wa	-	lary/Year		
2. If yes, is patient's application still pending?		(before ded :.(Self-Emp		Income:		
Yes □ No □		(0011 E111p	ioyinoni,			
3. If a decision reached, was patient awarded assistance?		S.Social Sec Unemploy Other Pub Alimony/ O	ment/ Dis	ance		
Yes No	5	.Real Esta	te Rentals	8 &		
4. If yes, what amount was awarded?		Leases 5. All Other S list) 7. Total Inco	,			
5. If a decision was reached and assistance not	L	above)				
awarded, please explain why the patient was denied?						

6. Is a third party responsible for the medical care you

## XIV. Guarantor Attestation

Patient declares under the penalty of perjury that all t information provided herein is true and correct to the best of his/her knowledge and further understands and agrees as follows:

- Providing false or misleading information, or the intentional omission of material information, will result in the denial of this application and could result in legal actions being taken against me/us.
- Patient authorizes Pipeline Health to verify any information listed in this application, including employment status and credit history, for the purpose of determining eligibility for patient discount.
- Patient fully understands that the Patient (Charity)
   Discount programs are a "Payor of Last Resort."
- Patient therefore hereby assign to Pipeline Health all benefits due from any liability action, personal injury claims, settlements, and all insurance benefits which may become payable, for illness/ injury for which Pipeline Health or its subsidiaries provided care.

Signature of Patient/Guarantor		
Date		
Signature of Spouse		
Date		
Sponsor		
Date		