LAJHealth
Los Angeles Jewish Health

Exhibit B
APPLICATION FOR FINANCIAL ASSISTANCE

Patient Account Number(s)_____

Application Name: _____ SSN_____Birthday_____

Spouse/Partner Name: _____ SSN_____ Birthday _____

Address _____ City _____ State_____ Telephone _____ Email _____

Family Status: List any spouse, domestic partner, or dependent children

Name: _____ Age _____ Relationship_____

Name: _____ Age _____ Relationship _____

Name: _____ Age _____ Relationship _____

Name: _____ Age _____ Relationship _____

Family Size: _____

(Use supplemental sheet if needed and check here □)

OTHER INFORMATION

MEDICAL INSURANCE- Please provide a photocopy of the patient's medical insurance cards

Primary Insurance _____ Policy # _____

2nd Insurance _____ Policy # _____

Prescription Drug Plan _____ Policy # _____

Other Coverage _____

EMPLOYMENT AND OCCUPATION

Employer: _____Position:_____

Contact Person & Telephone:_____

If Self-Employed Name of Business: _____

Employer: _____ Position: _____

Contact Person & Telephone: _____

If Self-Employed Name of Business: _____

The following is a true statement of all monthly income:

1. **MONTHLY INCOME**	**AMOUNT PER MONTH**
From Social Security Benefits … Direct Deposits to bank?	$_____
From Supplemental Social Security Direct Deposit to bank?	_____
From Other Government Agencies (Federal, State or City)	_____
Civil Service # _____R.R. Retirement # _____	_____
From Veteran's Pensions	_____
From Company Pensions. Name of Company	_____
From Union Pensions. Name of Union _____	_____
From Other Pensions … Name _____	
From Foreign Governments, including Pensions, Restitutions and Indemnification Payments	
Give Details _____	
From Interest on Bank Accounts	_____
From Dividends on Securities	_____
From Interest on Securities (Treasury Notes, Corporate Bonds, etc.)	_____
From Insurance Payments or Annuities. Name of Company	_____
From Real Estate (Rents, Interests, etc.)	_____
From Bequests, Legacies, or Trusts. Name of Estate or Trust _____	_____
Others, (Relatives and/or Friends, etc.) _____	_____
Total Monthly Income	_____

(Use supplemental sheet if needed and check here □)

I hereby declare that each and all of the foregoing statements are true, correct and complete. I also understand that Exhibit B is an integral part of my application and that my application may be rejected for any incorrect and incomplete information given herein.

_____ _____

Signature of Applicant or Designee Date