Kindred Hospitals

Charity Care/Financial Assistance Application Form – Confidential

Please fill out all the information completely. If it does not apply, write "NA." Attach additional pages if needed.

SCREENING INFORMATION
Select all that apply: Are you applying for Charity Care (*i.e.*, free care)? □ **Yes** □ **No** Are you applying for Financial Assistance (*i.e.*, reduced-price care)? □ **Yes** □ **No**
Do you need an interpreter? □ **Yes** □ **No** *If Yes, list preferred language:*
Has the patient applied for Medi-Cal? □ **Yes** □ **No**
Does the patient receive state public services such as EBT-SNAP, or WIC? □ **Yes** □ **No**
Is the patient currently homeless? □ **Yes** □ **No**
Is the patient's medical care related to a car accident or work injury? □ **Yes** □ **No**

PLEASE NOTE

- For documentation of income, we only request recent paystubs or income tax returns. We accept, but do not require, other forms of documentation of income.
- Patients applying only for Financial Assistance may receive less financial assistance than what may be available to them under the Charity Care program.
- We cannot guarantee that you will qualify for financial assistance, even if you apply.
- Once you send in your application, we may check all the information and may ask for additional information or proof of income.
- Within 14 calendar days after we receive your completed application and documentation, we will notify you if you qualify for assistance.

PATIENT AND APPLICANT INFORMATION			
Patient first name	**Patient middle name**		**Patient last name**
□ Male □ Female □ Other (may specify _____)	Birth Date		**Patient Social Security Number (optional*)** ***Optional, but needed for more generous assistance above state law requirements***
Person Responsible for Paying Bill	Relationship to Patient	Birth Date	**Social Security Number (optional*)** ***Optional, but needed for more generous assistance above state law requirements***
Mailing Address _____ _ _____ _ City State Zip Code			Main contact number(s) ( ) _____ ( ) _____ Email Address: _____

Employment status of person responsible for paying bill.
□ **Employed** (date of hire: _____) □ **Unemployed** (how long unemployed: _____)
□ **Self-Employed** □ **Student** □ **Disabled** □ **Retired** □ **Other** (_____)

FAMILY INFORMATION

List family members in your household, including you. ***Patient's Family means the following: (1) For persons 18 years of age and older, spouse, domestic partner, as defined in Section 297 of the Family Code, and dependent children under 21 years of age, or any age if disabled, consistent with Section 1614(a) of Part A of Title XVI of the Social Security Act, whether living at home or not. (2) For persons under 18 years of age or for a dependent child 18 to 20 years of age, inclusive, parent, caretaker relatives, and parent's or caretaker relatives' other dependent children under 21 years of age, or any age if disabled, consistent with Section 1614(a) of Part A of Title XVI of the Social Security Act.***

FAMILY SIZE _____ *Attach additional page if needed*

Name	Date of Birth	Relationship to Patient	If 18 years old or older: Employer(s) name or source of income	If 18 years old or older: Total gross monthly income (before taxes):	Also applying for financial assistance?
					Yes / No
					Yes / No
					Yes / No
					Yes / No

All adult family members' income must be disclosed. Sources of income include, for example:
- Wages - Unemployment - Self-employment - Worker's compensation - Disability - SSI - Child/spousal support
- Work study programs (students) - Pension - Retirement account distributions - Other (*please explain_____)*

INCOME INFORMATION

***REMEMBER**: You must include proof of income with your application.*

You must provide information on your family's income. Income verification is required to determine financial assistance. All family members 18 years old or older must disclose their income. If you cannot provide documentation, you may submit a written and signed statement describing your income. Please provide proof for every identified source of income.

Proof of income means:

- Current pay stubs (within *3 months*); or
- Last year's income tax return, including schedules if applicable.

You may, but are not required to, provide additional proof of income beyond current pay stubs and last year's income tax return.

If you have no proof of income or no income, please attach an additional page with an explanation.

EXPENSE INFORMATION

We use this information to get a more complete picture of your financial situation.

Monthly Household Expenses:

Rent/mortgage $_____

Medical expenses $_____

Insurance Premiums $_____

Utilities $_____

Other Debt/Expenses $_____ (*child support, loans, medications, other*)

ADDITIONAL INFORMATION

Please attach an additional page if there is other information about your current financial situation that you would like us to know, such as financial hardship, excessive medical expenses, seasonal or temporary income, or personal loss.

PATIENT AGREEMENT

I understand that ***Kindred Hospital*** may verify information by reviewing credit information and obtaining information from other sources to assist in determining eligibility for financial assistance or payment plans.

I affirm that the above information is true and correct to the best of my knowledge. I understand if the financial information I give is determined to be false, the result may be denial of Charity Care or Financial Assistance, and I may be responsible for and expected to pay for the services provided.

_____ _____

Signature of Person Applying Date