LAJI Health
Los Angeles Jewish Health

APPLICATION FOR FINANCIAL ASSISTANCE

Patient Account Number(s)_____

Applicant Name: _____SSN_____Birthdate_____

Spouse/Partner Name: _____SSN_____Birthdate_____

Address_____City_____State___Zip_____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: _____

LAJI Health
Los Angeles Jewish Health

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