# Application for Uncompensated Care

| SECTION 1.- FAMILY/GUARANTOR INFORMATION | |
|---|---|
| Total Number in Family: | |
| # of Dependents Under 21: | |
| Name of Guarantor: | |
| Relationship to patient: | |
| Citizenship Status | |

| SECTION II.- GROSS MONTHLY INCOME | |
|---|---|
| Mother: | |
| ☐ Employment | $______ |
| ☐ Disability | $______ |
| ☐ Unemployment | $______ |
| ☐ Retirement | $______ |
| ☐ Medi-cal | $______ |
| ☐ Other: | $ |
| Father | |
| ☐ Employment | $______ |
| ☐ Disability | $______ |
| ☐ Unemployment | $______ |
| ☐ Retirement | $______ |
| ☐ Medi-cal | $______ |
| ☐ Other: | $______ |
| TOTAL INCOME: | $______ |

| SECTION III.- LIQUID ASSETS | |
|---|---|
| Checking Account # | $_______ |
| Bank Name: | |
| Branch: | |
| Savings Account#: | $_______ |
| Bank Name: | |
| Branch: | |
| Other: | $_______ |
| Specify | |
| TOTAL LIQUID ASSETS: | $_______ |

| SECTION IV.- NON-LIQUID ASSETS | Make | Year | Amount owed | Monthly payment | Value |
|---|---|---|---|---|---|
| Car 1 | | | | | $______ |
| Car 2 | | | | | $______ |
| Other | | | | | $______ |
| | | Total | | | |
| Do you own or rent residence? | | | Own | Rent | |
| Do you own other property? | | | Yes | No | |
| Address/Location: | | | | | |
| | | Value | Amt Owed | Equity | |
| Other property | | | | | |
| | | | | TOTAL Non- LIQUID ASSETS: | $______ |

| SECTION V.- MONTHLY EXPENSES | Mother | Father |
|---|---|---|
| Alimony and/or child support | $______ | $______ |
| Day Care Costs for Children | $______ | $______ |
| Health Insurance Premiums | $______ | $______ |
| Work expenses ($75 per person max.) | $______ | $______ |
| Total Medical/Dental Expenses | $______ | $______ |
| Charge Accounts/Loans/Credit Cards: | $______ | $______ |
| Name: | $ | $ |
| Name: | $______ | $______ |
| Name: | $ | $ |
| MasterCard Limit | $______ | $______ |
| Visa limit: | $______ | $______ |
| TOTAL EXPENSES | $______ | $______ |

**DOCUMENTS REQUIRED:**

- ☐ Last year's Tax Return or 3 months' worth of pay stubs
- ☐ Copy of bank statements {2 months)
- ☐ Rental receipt or mortgage payment {3 months)
- ☐ Other: (specify)

PURPOSE: The purpose of this information is to determine your ability to pay for services at Children's Hospital LA, or your possible eligibility for a medical assistance program. This information is NOT an application for Medi-cal, and California Children's Services, County Medically Indigent Services Program or any other county's assistance program. You MUST CONTACT THE DEPARTMENT OF SOCIAL SERIVCES IN YOUR COUNTY OF RESIDENCE TO APPLY FOR ASISTANCE PROGRAMS.

I certify the above information to be accurate and complete. I understand that the hospital reserve the right to verify all information. I agree to notify Patient Business Services of any change in my financial information within 10 days of the change.

I UNDERSTAND THAT I AM STILL RESPONSIBLE FOR THE FULL AMOUN'T OF MY CHARGES AT CHILDRENS HOSPITAL LOS ANGELES.

____________________ Signature of Parent/ Guardian

____________________ Date

____________________ Witness/ Translator

____________________ Hospital Representative