Del Amo Hospital
23700 Camino Del Sol
Torrance, California 90505
Telephone: (310)530-1151

Dear Date:

I am sending you this letter in attempt to assist you with your account here at Del Amo Hospital. I am sending you a copy of our Application for Discount or Charity for your stay for dates of service: _____; due to no insurance coverage.

Our hospital has a Charity & Discount program available to all patients. You will continue to be billed for your stay here at Del Amo Hospital until your application has been received in our office. We will need supporting documentation with your signed Application for Discount or Charity in order to review your case.

Supporting documentation for Charity should be in the form of the following:

- **A copy of the last two paychecks (if applicable)**
- **A copy of last year's W-2's (if applicable)**
- **Income Tax Return for prior year**
- **Statement from Employer (if applicable and the paychecks or W-2's cannot be obtained)**
- **SSI Statement of Earnings (if applicable)**
- **List and proof of paid Medical expenses (EOMB's, cancelled checks, print outs, receipts)**
- **A list of monetary assets and their value.**
- **Any additional information you feel will help with our review.**

Supporting documentation for Discount should be in the form of the following:

- **A copy of the last two paychecks (if applicable) or Income Tax Return for prior year**

If you do not wish to apply for the Charity & Discount please remit your payment today to:

Del Amo Hospital
23700 Camino Del Sol
Att: Business Office
Torrance, Ca 90505

If you should have any questions, please feel free to contact me at 310-530-1151

Thank you in advance for your time in this matter.
Respectfully,

Del Amo Hospital
Business Office
Cc: File

Financial Disclosure Form

Del Amo Hospital
23700 Camino Del Sol
Torrance, CA 90505

Patient No: _____
Admit Date: _____
Date completed: _____
Approval: _____

THIS FORM IS TO BE COMPLETED BY PERSON RESPONSIBLE FOR BILL
The information requested is to all02+ow us to assist you in establishing a reasonable payment program and is confidential.

PATIENT:

1. Name: _____ SSN: _____

2. Address: _____
   Street _____ City _____
   State _____ Zip _____

3. Employment: _____
   Employer _____ Phone Number _____
   Street _____ City _____
   Years of employment _____

4. Are you disabled? _____ If yes, disability:

RESPONSIBLE PARTY:

5. Name: _____ SSN: _____

6. Address:
   Street _____ City _____
   State _____ Zip _____

7. Employment:
   Employer _____ Phone Number _____
   Street _____ City _____
   Years of employment _____

8. Are you disabled? _____ If yes, disability:

DEPENDENTS OF RESPONSIBLE PARTY (SPOUSE):

9. Name: SSN:

10. Address:

Street City

State Zip

11. Employment:

Employer Phone Number

Street City

Years of employment

12. Are you disabled? If yes, disability:

DEPENDENTS OTHER THAN SPOUSE FOR WHICH YOU PROVIDE FOOD AND SHELTER:

13. Ages:
14. Are any of the above dependents employed? _____ Where?
15. Are any of the above dependents disabled? _____ Disability:
16. Which of the above dependents do not live with you?
17. Why?

INSURANCE:

18. Is the above patient covered by any health insurance through an employer or private plan?

☐ Y ☐ N

If yes, name the primary insurance:

Benefits coverage:

Name of Secondary insurance:

Benefits coverage:

RESPONSIBLE PARTIES FINANCIAL INFORMATION

17. Present Employer(s) All Sources	Occupation	Work Phone	Monthly Gross Pay	Monthly Take Home	Years On Job

a)					
b)					
c)					
d)					

18. Any Other Source of Income: _____ Monthly Amount:

Total Monthly Income:

PLEASE LIST AVAILABLE ASSETS: (Take Home)

CARS	$	CHECKING	$
HOMES	$	STOCKS/BONDS	$
SAVINGS	$	LIFE INSURANCE	$
OTHER	$	REAL ESTATE	$
OTHER	$		

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19. Monthly Expenses	**Monthly Payments**	**Balance**	**Comments / Purpose**
a) Food	$_____	$_____	_____
b) Gas Heat	$_____	$_____	_____
c) Electric	$_____	$_____	_____
d) Water	$_____	$_____	_____
e) Telephone	$_____	$_____	_____
f) Transportation, Gasoline	$_____	$_____	_____
g) Rent / Mortgage Payment	$_____	$_____	_____
h) 2nd Mortgage	$_____	$_____	_____
i) Alimony, Child Support	$_____	$_____	_____
j) Auto 1	$_____	$_____	_____
k) Auto 2	$_____	$_____	_____
l) Car Insurance	$_____	$_____	_____
m) Life Insurance	$_____	$_____	_____
n) Health Insurance	$_____	$_____	_____
o) Credit Card 1	$_____	$_____	_____
p) Credit Card 2	$_____	$_____	_____
q) Credit Card 3	$_____	$_____	_____
t) Bank Loan 1	$_____	$_____	_____
u) Bank Loan 2	$_____	$_____	_____
v) Finance Co. 1	$_____	$_____	_____
w) Finance Co. 2	$_____	$_____	_____
x) Other	$_____	$_____	_____
y) Other	$_____	$_____	_____
Total Monthly Expenses			_____

Please List Any Other Financial Conditions Which Should Be Considered in Establishing a Payment

Plan: _____

_____

_____

In order to receive free or discounted healthcare, you must cooperate fully with our need for accurate and detailed financial information, including the timely production of necessary documentation to support this application for financial need. Completion of this application does not guarantee that you will be eligible to receive free or discounted healthcare.

I hereby authorize representatives of **Del Amo Hospital**, its affiliates and their respective agents and employees to make whatever inquires necessary to verify the information furnished on this form, or to release any information regarding this treatment and/or hospitalization to any insurance company or third party to seek settlement of this account. I hereby state that to the best of my knowledge the information given above is true and complete. I agree to notify **Del Amo Hospital** of any material changes in my financial situation. I further authorize **Del Amo Hospital** its affiliates and their respective agents and employees to review and/or inquire into my credit history using any means available to obtain a current Credit Bureau History Report.

Date Signed

Witness Spouse

For additional information or questions, you may contact ***Del Amo Business Office Representative:***

Name_____telephone #_____