



27200 Calaroga Ave, Hayward, CA 94545

CHARITYCAREPOLICY

EXHIBIT B

STATEMENTOFFINANCIALCONDITION/FINANCIALASSISTANCEAPPLICATION

PATIENT NAME _____ SPOUSE _____

ADDRESS _____

PHONE _____ SSN: _____

ACCOUNT # _____

(PATIENT)

(SPOUSE)

FAMILYSTATUS: List all dependents that you support

Name

Age

Relationship

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____

EMPLOYMENTANDOCCUPATION

Employer: _____ Position: _____

Contact Person & Telephone Number: _____

If Self-Employed, Name of Business: _____

Spouse Employer: _____ Position: _____

Contact Person & Telephone Number: _____

If Self-Employed, Name of Business: _____

CURRENTMONTHLYINCOME

		Patient	Spouse
	Gross Pay (Before Deductions)		
Add:	Income from Operating Business (if Self-Employed)		
Add:	Other Income		
	Interest & Dividends	_____	_____
	From Real Estate	_____	_____
	Social Security	_____	_____
	Other (Specify)	_____	_____
	Alimony or Spousal Support	_____	_____
Subtract:	Alimony, Support Payments Paid		
Equals	Current Monthly Income	_____	_____

Total Current Monthly Income (Patient + Spouse) = \$ _____

FAMILY SIZE

Total Family Members: _____

(add patient, spouse and dependents from above)

Yes No

Do you have health insurance? _____

Are you eligible for any government programs? _____

Do you have other insurance that may apply (such as auto policy)? _____

Were your injuries caused by a third party? (such as during car accident)? _____

By signing this form, I agree to allow St. Rose Hospital to check employment status and credit history for the purpose of determining my eligibility for financial assistance. I understand that I may be required to provide proof of the information I am providing.

(Signature of Patient or Guarantor)

(Signature of Spouse)

Date

