Foothill Regional Medical Center

Instructions for the Charity Application

The following information and supporting documents must be provided to evaluate this application for a possible reduction of hospital expenses provided by Alta Hospitals System LLC.

Please complete all sections of the application and provide applicable documents. Return the application to the Admitting Department or return to the Business Office at the address below:

Alta Hospitals Systems, LLC
Attn: Business Office
P. O. Box 515202
Los Angeles, CA 90051-6502

Should you need assistance or have any questions regarding the Charity Application, please call (562) 293-3200.

List of documents required to complete Charity Application:

Proof of Gross Income
*Check Stubs (last 3 months)
*Employers Statement
*W-2 Form
*Complete Tax Return
*Profit/loss statement from accountant (if self-employed)
*Homeless Affidavit
*Unemployment Benefits /EDD (3 months paystubs)
*Social Security / Disability
*Workers Compensation
*Strike Benefits
*Welfare / AFDC / General Relief
*Veteran's Benefits
*Stipends
*Alimony
*Child Support
*Military Family Allotments
*Private or Government Pensions
*Proceeds from Insurance or Annuity Payments
*Income from Dividends
*Interest Income
*Rents
*Royalties
Farm Income
*Support From family members or someone not living in the household (they will not be responsible for your bill)

***Assets**
*Bank Statements
(3 months, all pages, for all accounts)
*Copy of ID and Social Security Card

Foothill Regional Medical Center

|| Central Business Office Location: P.O. Box 515202 Los Angeles, CA 90051 || Tel. No. (562) 293-3200 ||

Charity Care and Low Income Financial Assistance Application

To be completed by financially responsible party

Please complete this application in its entirety.

Date: _____

Account Number: _____

Patient's Name: _____ Spouse's Name: _____

Patient's Employer: _____ Spouse's Employer: _____

Patient's Address: _____

City / State / Zip: _____

Phone Number: _____

Date of Birth: _____ Spouse's Date of Birth: _____

Social Security Number: _____ Spouse's Social Security Number: _____

Guarantor's Name: _____

Guarantor's Employer: _____

Guarantor's Address: _____ Spouse's Phone Number: _____

Guarantor's Social Security Number: _____

As provided for in Federal Law, I hereby request that Alta Hospitals System, LLC. make a determination of my eligibility for uncompensated services. I understand that the information that I submit concerning my annual income and family size is subject to verification by the hospital. I also understand that if the information is determined to be false, such determination will result in a denial of providing services as uncompensated services, and that I will be liable for charges for services provided.

Please fill out the following:	Total for latest 12 months	
	Patient	Spouse
Wages	$ _____	$ _____
Social Security	$ _____	$ _____
Strike Benefits	$ _____	$ _____
Alimony - Child Support	$ _____	$ _____
Military Allotment	$ _____	$ _____
Dividends/Interest	$ _____	$ _____
Pensions	$ _____	$ _____
Unemployment	$ _____	$ _____
Disability	$ _____	$ _____
IRA	$ _____	$ _____
Trust Account	$ _____	$ _____
Interest Income	$ _____	$ _____
Other	$ _____	$ _____

Proof of Income attached :{ } Current W-2 Form { }Pay Check Stubs { }Complete Current Tax Return

Expenses:

House / Rent Payment $ _____

Food $ _____

Water $ _____

Gas & Electricity $ _____

Trash $ _____

Child Support $ _____

Auto Expenses $ _____

Insurance $ _____

Credit Cards:

Company: _____ Balance Owing $ _____

Amount Available $ _____

Company: _____ Balance Owing $ _____

Amount Available $ _____

Company: _____ Balance Owing $ _____

Amount Available $ _____

Medical Bills:

Hospital / Doctor Names _____

_____

Amount Owed $ _____

_____

Number of family members in my household: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Bank References:

Checking: Name/Branch: _____ Account# _____

Savings: Name/Branch: _____ Account# _____

Assets:

Do you own your own Home? _____ Value: _____

Is your home a Duplex / Triplex? _____

Do you own other Property? _____ Value: _____

Do you own your automobiles? _____ Value: _____

Statement

I certify the information provided is true and accurate to the best of my knowledge. Further, I have or will apply for any assistance (Medical, Medicare, insurance, etc.) that may be available for payment of medical services, and that I will take any action reasonably necessary to obtain such assistance and will assign or pay to the hospital the amount recovered for medical services.

I understand this application is made for the hospital to evaluate eligibility for Charity Services. I also understand the hospital will verify the information, which may include obtaining a credit report. If the information I have given proves to be untrue, or if I fail to comply with the referral process for Medical, Medicare, California Children's Services, or other identified programs this will result in forfeiture of the right to be considered for Charity Care.

I affirm that the statements made herein are true and correct to the best of my knowledge.

Signature of the applicant: _____ Date: _____

Witness: _____ Date: _____

HOMELESS AFFIDAVIT

I, _____, herby certify that I am homeless, have no permanent address, no job, savings, or assets, and no income other than potential donations from others and or General Relief.

I also acknowledge all of the information provided herein is true and correct. I understand that providing false information will result in denial of this application. Additionally, depending upon local or state statutes, providing false information to defraud a hospital for obtaining goods or services may be considered an unlawful act. I also acknowledge and consent that a credit report may be obtained or other such measure may be taken to verify the information provided herein. I fully understand that Alta Hospitals Systems LLC. Charity Care program is a "Payer of Last Resort" and herby confirm all prior assignments of benefits and rights, which may include liability actions, personal injury claims, settlements, and any and all insurance benefits that may become payable, for fitness or injury, for which Alta Hospitals Systems LLC provided care.

_____ _____

Patient/Guarantor Signature Date