Barlow
RESPIRATORY HOSPITAL

FINANCIAL ASSISTANCE CHECKLIST

The attached financial assistance application is used to determine your eligibility for charity care (free care) or discounted care at our facility. Please complete and sign this form and return it with copies of the documentation that applies to you. You may apply at any time; there is no deadline to apply.

Return the application to the Business Services Department at our Barlow Main location, or mail to: Barlow Respiratory Hospital, Attention: Business Services, 2000 Stadium Way, Los Angeles, CA 90026-2696.

Documentation that may help your application (copies only, no originals):

- Recent pay stubs, your most recent income tax return, or other reasonable proof of income.
- Medi-Cal denial notice, if applicable.
- Unemployment compensation determination or termination notice, if applicable.
- A listing of currently outstanding medical debt, if applicable.
- A listing of out-of-pocket medical costs incurred over the past 12 months, if applicable.

Have you: (1) completed the application? ____ (2) signed the application? ____

Your signature verifies the accuracy of the information provided and authorizes Barlow Respiratory Hospital to verify the information provided.

Signature: _____ Date: _____

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FINANCIAL ASSISTANCE APPLICATION

Patient Name: _____ Spouse: _____

Address: _____

Phone: _____

Household members

If you are over 18, list your spouse or domestic partner and dependent children under 21. If you are under 18, list your parents or caretaker relatives and their other children under 21.

Name: _____ Age: ____ Relationship: _____
Annual Income: _____

Name: _____ Age: ____ Relationship: _____
Annual Income: _____

Name: _____ Age: ____ Relationship: _____
Annual Income: _____

Family Income

Total family income (include your income and the income of those listed above):

_____

Please attach recent pay stubs, your most recent income tax return, or other reasonable proof of income.

Existing Insurance

Do you have any health insurance (Medicare, Medi-Cal, or private)? Yes: ____ No: ____ Payor: _____

Is your injury covered by workers' compensation, automobile insurance, or other insurance? Yes: ____ No: ____

Annual Medical Costs

Amount paid in the past 12 months to Barlow Respiratory Hospital: _____ To other providers: _____

My signature verifies the accuracy of the information provided and authorizes Barlow Respiratory Hospital to verify it. I understand that financial assistance is intended solely for my benefit and does not relieve third parties of liability for payment. I understand that if I do not qualify I will be personally liable for the charges, and that I may appeal a determination in writing with additional documentation.

Signature of Patient or Legal Guardian: _____
Date: _____