



Charity Application

Application should be returned within 21 days of receipt. When submitting your application, please provide the following information.

1. Most recent paycheck stub copy.
2. Current month's bank statement.
3. Most recently filed tax return and W2 copy.

Your credit report will be accessed. Questions, call Customer Service at 702-894-5700.

Patient #	Hospital Name
Date of Application	Diagnosis
Date of Service	Is the Patient Deceased?
Is the Patient Homeless?	
Charity Care Requested By	
Have You Ever Applied for Medicaid or Any Other State/County Assistance? If Yes, Please <u>List the Following:</u>	If you have not applied for State/County assistance, why not? Agency Name;
Caseworker Name;	Phone Number;

If denied by Medicaid send denial letter.

If approved send copy of approval letter.

I. PATIENT

Last Name	First Name	MI	Marital Status	Social Security #
Street Address				
City	State	Zip	How long at this address?	Home Phone#
Are you a U.S. Citizen?				

II. RESPONSIBLE PARTY

Last Name	First Name	MI	Marital Status	Social Security #
Street Address				
City	State	Zip	How long at this address?	Home Phone #
Are You a U.S. Citizen?			Drivers License #	
<u>Relationship to Patient</u>				
Employer's Name and Address			Business Phone	Length of Employment
Position/Title			Hourly Rate	Pay Period
<u>Total Hours Worked Per Month (Reg/OT)</u>				

Annual Gross Income \$ _____ Gross Monthly Income \$ _____

Other Monthly Income Besides Employment \$ _____

Total Monthly Income \$ _____ Total Family Monthly Income \$ _____

III. SPOUSE

Last Name _____ First Name _____ MI _____ Social Security # _____

Employer's Name and Address _____ Business Phone _____ Length of Employment _____

Position/ Title _____ Hourly Rate \$ _____

Total Hours Worked per Month (Reg./OT) _____

Annual Income \$ _____ Gross Annual Income \$ _____

Gross Monthly Income \$ _____ Pay Period _____

IV. HOUSEHOLD INFORMATION (ALL PERSONS IN HOUSEHOLD INCLUDING SELF)

Name	DOB	Relationship to Responsible Party

Total Persons In Household: _____

If You or Anyone In Your Family Was Covered in the Last 6 Months but is no Longer Covered, Please List the Following:

Insurance Company Name and Address

Policy # _____ Group # _____ Employment Related? _____

Name of Policy Holder _____ Beginning Coverage Date _____ Name of Persons Covered _____

V. MISCELLANEOUS INCOME PER MONTH

Dividends, Interest \$ _____ Pensions \$ _____

Public Assistance/Food Stamps	\$ _____	Investment/Rental Income	\$ _____
Social Security	\$ _____	Grants	\$ _____
Unemployment/Workers Compensation	\$ _____		
Child Support/Alimony	\$ _____	Other	\$ _____
TOTAL MONTHLY MISCELLANEOUS INCOME: \$ _____			

VI. MISCELLANEOUS EXPENSES

Do you own or rent Housing?	_____	Market Value of Home	\$ _____
Outstanding Balance on Home Loan	\$ _____	Years Left on Home Loan	_____
Outstanding Balance on Auto Loan	\$ _____	Years Left on Auto Loan	_____
Outstanding Balance on Medical Bills	\$ _____		
List Monthly Expenses for following:			
Rent/Mortgage	\$ _____	Food/Clothing	\$ _____
Insurance (Homeowners/Medical/Life/Auto/Other)	\$ _____		
Property Tax	\$ _____	Car Payments	\$ _____
Electric/Water/Gasoline	\$ _____	Telephone/Cellular Phone	\$ _____
Alimony/Child Support	\$ _____	Credit Cards	\$ _____
Loans	\$ _____	Medical Bills/Medications	\$ _____
Other (Specify)	\$ _____		
Total Monthly Miscellaneous Expenses	\$ _____		

VII. MONTHLY NET INCOME

Responsible Party's Monthly Income		\$ _____
Spouse's Monthly Income (If Applicable)	+	\$ _____
Total Monthly Miscellaneous Income	+	\$ _____
Total Monthly Miscellaneous Expenses	-	\$ _____
Total Monthly Net Income	=	\$ _____

VIII. ASSETS/EQUITY

List Checking Bank Name, Bank Address, Account Numbers and Average Balances;

List Savings Bank Name, Bank Address, Account Numbers and Average Balances;

Is treatment related to a third party liability claim? _____

If yes; do you have an attorney? _____

Attorney name, address, phone number:

List Dollar Value for the Following:

Checking Account(s)	\$ _____	Home	\$ _____
Other Real Estate	\$ _____	CDs/Investments/IRA(s)	\$ _____
Savings Account(s)	\$ _____	Trust Funds	\$ _____
Life Insurance Cash Value	\$ _____	Motorhome(s)/Boat	\$ _____

Motorcycle \$ _____ Other Cash Value \$ _____
Automobile(s) \$ _____
Make: _____
Model: _____
Year: _____

List Other Assets: _____

Total Equities: \$ _____

IX. COMMENTS

Applicant Signature: _____ Date: _____

Responsible Party Signature: _____ Date: _____

Hospital Representative Signature _____ Date: _____

Please return application and all required documents to:

UHS Western Region CBO
Customer Service Dept
2700 Fire Mesa St
Las Vegas, NV 89128
Ph: 866-823-4250

Or by facsimile:

702-360-5071
