Kindred Hospitals – Southern California

Application Form

Charity Care and Financial Assistance

Patient Name_____

Address_____

Telephone Numbers_____

Name(s) of all members in household _____

_____

Employment of all members in household:

1. Name _____
   Employer Name_____
   Monthly Income_____
2. Name_____
   Employer Name_____
   Monthly Income_____
3. Name_____
   Employer Name_____
   Monthly Income_____

Reason(s) for the request for Charity Care or Financial Assistance _____

_____

_____

To complete this application, the following documents must be attached: Prior Year 1040 Income Tax Return; Prior two months employment payroll check statements; outstanding balances of medical bills; proof of payment of out-of-pocket medical expenses within the last twelve (12) months. Documentation of ineligibility for government sponsored programs including Medi-Cal and Medicare.

The undersigned responsible party attests that all information provided in this application and attached documents is correct and valid. The undersigned responsible party authorizes Kindred Hospitals – Southern California to investigate the financial data presented in this application including employment records and status, credit history, and any other related data source that supports the financial information presented in this application.

Name of Responsible Party _____

Signature of Responsible Party _____

Date of Application_____