SILVER LAKE MEDICAL CENTER
CHARITY CARE APPLICATION
Request for Uncompensated Services

Account# Date of Service:

Name:
First Middle Last

Address:
Number/Street City State Zip

Telephone ( )

Sex Code 1-Male 2-Female

Date of Birth: / /

Ethnicity: Enter ethnicity code as follows:
(1) White (4) Native American/Eskimo
(2) Black (5) Asian/Pacific Islander
(3) Hispanic (6) Other

Family Size:

Name Age Sex

Family Principal Income Source:

Code:

(01) Professional/Technical Employment
(02) Labor/Production Employment
(03) Agricultural Employment
(04) Service/Sales Employment
(05) Unemployment Compensation
(06) Retirement Income
(07) Disability Income
(08) General Relief
(09) Other Income Source
(10) None

Potential 3rd Party Payor Source:

Code:

(1) Private Insurance
(2) Medi-Cal
(3) Medicare
(4) Self Pay
(5) Other
(6) None

INCOME: List income for family from:	MONTHLY ANNUAL
Wages (Self)	
(Spouse)	
(Other Family Members)	
Farm or self-employed	
Public Assistance	
Social Security	
Unemployment Compensation	
Worker's Compensation	
Strike Benefits	
Alimony	
Child Support	
Military Family Allotments	
Pensions	
Income from Dividends, Interest, Rent	

TYPE OF SERVICE: Code: _____

(1) Hospital Inpatient
(2) Hospital Outpatient
(3) Hospital Emergency Room

UNITS OF SERVICE:

I/P Days _____
O/P Visits _____
E/P Visits _____

Billed Amount $ _____

Repayment Collected $ _____

Other Write-Offs $ _____

Patient Liability $ _____

Date of Service:_____

Expenses (Monthly)

Mortgage/Rent	$
Medical Insurance	$
Utitilies	$
Auto Insurance	$
Telephone	$
Medical Bills	$
Food	$
Hospital	$
Finance Companies	$
Physicians	$
Credit Union	$
Medications	$
Auto Loans	$
Total Expenses:	$

Net Worth

Do you own your home? ( ) Yes ( ) No

If yes, estimate value: _____
Less outstanding owed: _____
Net Value: _____

Do you own other property? ( ) Yes ( ) No

If yes, estimate value: _____
Less outstanding owed: _____
Net Value: _____

Do you own automobile? ( ) Yes ( ) No

Amount _____ Net _____

Model/Make Year	Value Owed	Value

Name/Branch: _____ Account# _____

Name/Branch: _____ Account# _____

Total Net value of all items in this section: _____

Liability Computation

Plus Total Monthly Gross Income	(A) _____	Adjusted Net Monthly
Minus Monthly Deductions	(B) _____	
Income	(A-B) _____	

I declare under penalty of perjury that the answers I have given are true and correct to the best of my knowledge

I agree totell the provider of service within ten (10) days of there are any changes in my (or the persons on whose behalf I am acting) income, property, expenses or in the persons in the household or any change of address.

I understand the county is required by law to keep any information I provide confidential.

I further agree, that in consideration for receiving health care services as a result of an accident or injury, to reimburse the county from the proceeds of any litigation or settlement resulting from such act.

_____ _____

Signature Date

For Hospital Use Only: _____ Accepted _____ Denied

Comments: _____

_____ _____

Signature Date