**FULL CHARITY CARE, DISCOUNTED CHARITY CARE AND HIGH MEDICAL CHARITY CARE**
**STATEMENT OF FINANCIAL CONDITION**

APPLICANT'S NAME: _____ SPOUSE NAME: _____

ADDRESS: _____ PHONE: _____

ACCOUNT #: _____ SSN: _____

**FAMILY STATUS (List all dependents that you support)**

| NAME | RELATIONSHIP | AGE | SEX |
|---|---|---|---|
| _____ | _____ | _____ | ___ F ___ M |
| _____ | _____ | _____ | ___ F ___ M |
| _____ | _____ | _____ | ___ F ___ M |
| _____ | _____ | _____ | ___ F ___ M |
| _____ | _____ | _____ | ___ F ___ M |
| _____ | _____ | _____ | ___ F ___ M |

**FAMILY SIZE**

Total Family Members (add applicant, spouse and dependents from above): _____

**EMPLOYMENT AND OCCUPATION**

APPLICANT'S EMPLOYER: _____ POSITION: _____
CONTACT PERSON& TELEPHONE: _____
IF SELF EMPLOYED, NAME OFBUSINESS: _____
SPOUSE'S EMPLOYER: _____ POSTION: _____
CONTACT PERSON & TELEPHONE:_____
IF SELF EMPLOYED, NAME OF BUSINES:_____

CURRENT INCOME (Select One): Weekly___ Bi-Weekly___ Monthly___ Yearly ___Other___

| CATEGORY | APPLICANT | SPOUSE | OTHER FAMILY MEMBERS |
|---|---|---|---|
| Gross Pay (before deductions): | $ _____ | $ _____ | $ _____ |
| Public Assistance: | $ _____ | $ _____ | $ _____ |
| Social Security: | $ _____ | $ _____ | $ _____ |
| Unemployment Compensation: | $ _____ | $ _____ | $ _____ |
| Alimony: | $ _____ | $ _____ | $ _____ |
| Child Support: | $ _____ | $ _____ | $ _____ |
| Military Family Allotments: | $ _____ | $ _____ | $ _____ |
| Pension: | $ _____ | $ _____ | $ _____ |
| Income from Dividends and Interest: | $ _____ | $ _____ | $ _____ |
| Income from Rent, Real Estate or Property: | $ _____ | $ _____ | $ _____ |
| **TOTAL:** | **$**_____ | **$**_____ | **$**_____ |

**MEDICAL EXPENSES INCURRED AND PAID**

Total patient's out-of-pocket costs incurred at this hospital in prior 12 months (net of any discounts or write-offs:
$ _____

Total patient and patient's family out-of-pocket medical expenses (including but not limited to, hospital services, physician service, drugs, and all other medical services) paid by the paitnet or patient's family in prior 12 months :
$ _____

IN ORDER FOR US TO CONSIDER YOUR REQUEST, YOU MUST INCLUDE THE FOLLOWING ITEMS:

- A COMPLETED FINANCIAL APPLICATION
- LAST 3 MONTHS OF PAY CHECK STUBS OR INCOME STATEMENTS
- LAST FILED INCOME TAX RETURN (LESS THEN 2 YEARS OLD)
- VALID MEDI-CAL DENIAL and or COVERED CALIFORNIA DENIAL
- STATEMENT ON ANY MONETARY ASSETS (CHECKING AND SAVINGS BANK STATEMENTS, STOCKS, BONDS, ETC…

**NOTE:** Application process is not a guarantee that you will be approved for the Charity Program. Some type of payment must be rendered every month until application is approved.

_____ Date _____
(Applicant's signature)

_____ Date _____
(Spouse's signature)